aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel
Washington, D.C.

March 30, 1977

5:00 p.m.	Business Meeting	*Jackson Room*
7:30 p.m.	Cocktails	*Kalorama Room*
8:30 p.m.	Dinner	*Jackson Room*

Guest: *Mr. Terry Lierman, Professional Staff Member, Senate Subcommittee on Labor-HEW Appropriations*

March 31, 1977

8:30 a.m.	Business Meeting	*Jackson Room*
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon and Executive Council Business Meeting	*Conservatory Room*
4:00 p.m.	Adjourn	

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

1977 MEETING DATES

CAS Administrative Board Washington, D.C.	January 12-13 March 30-31 June 22-23 September 14-15
CAS Interim Meeting Washington, D.C.	June 22
AAMC Annual Meeting Washington, D.C.	November 5-10

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

March 30-31, 1977

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

January 12-13, 1977

Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members

A. Jay Bollet
Chairman (Presiding)
Robert M. Berne
F. Marion Bishop
Carmine D. Clemente
G.W.N. Eggers, Jr.
Daniel X. Freedman
Rolla B. Hill*
Thomas K. Oliver, Jr.
Roy C. Swan
Samuel O. Thier
Leslie T. Webster

Staff

Judy Braslow*
John A.D. Cooper*
Kat Dolan*
James B. Erdmann*
Mary H. Littlemeyer
Thomas E. Morgan
Mignon Sample
James R. Schofield*
John F. Sherman*
August G. Swanson

Guests**

Stan Jones
David Blumenthal

ABSENT: Eugene Braunwald

The CAS Administrative Board Business Meeting convened on January 12 at 5:00 p.m. and adjourned at 8:00 p.m. A social hour was followed by dinner at 9:00 p.m. Dr. James R. Schofield, Director of the AAMC Division of Accreditation, discussed accreditation issues with the Board in an informal after-dinner session.

The meeting reconvened at 8:30 a.m. on January 13, when the Board was joined for discussion by members of the Senate Health Subcommittee. Following the usual custom, the CAS Administrative Board joined the other AAMC Boards for a luncheon meeting at 1:00 p.m.

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* For part of the meeting

** Staff, Senate Health Subcommittee, present January 13, 1977

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of September 15-16, 1976 were adopted as circulated.

II. Action Items

A. Ratification of LCME Accreditation Decisions

Dr. James Schofield was present with the Board throughout its January 12 session to discuss the various developments in accreditation including the current investigation by the Federal Trade Commission.

ACTION: The CAS Administrative Board voted unanimously to ratify the LCME accreditation decisions.

B. Guidelines for Functions and Structure of a Medical School

The document that appeared in the Executive Council Agenda (pages 84-99), according to Dr. Schofield, resulted from a document revised by the Liaison Committee on Medical Education after considering the many modifications and suggestions offered by the CAS Board on the earlier document. Many of the CAS Administrative Board's suggestions were adopted, he reported. His recommendation was that the document be adopted subject to a review after its use for a couple of years.

ACTION: The CAS Administrative Board voted unanimously to accept the LCME Guidelines for Functions and Structure of a Medical School.

C. AAMC Response to the DHEW Credentialing Report

Dr. Swanson briefed the CAS Administrative Board on the report issued last summer by the Subcommittee on Health Manpower Credentialing of the Public Health Service Manpower Coordinating Committee. Recommendations of the report, A Proposal for Credentialing Health Manpower, if implemented, could have a major impact on the health care industry. Among parent organizations responding to the "Proposal," was AAMC. The AAMC draft response appeared in the Executive Council Agenda (pages 72-83).

The CAS Administrative Board felt that without knowing more specifically what the document was responding to or the bases upon which the "Proposal" was made it was not in a position to make any recommendations to the draft.

Dr. Thier suggested that information be obtained on the perceived guidelines for quality against which the credential change or overview would be measured. Until such information becomes available, it is impossible to respond intelligently to the "Proposal."

D. Specialty Recognition of Emergency Medicine

The CAS Administrative Board discussed this matter at great length and reviewed its current status and the lists of organizations in favor of and opposed to the recognition of emergency medicine as a specialty. Dr. Clemente observed that no actual arguments for or against the issue had been presented and indicated that he, therefore, felt unable to take a position on the issue. The majority of the Board, however, voiced strong opposition to the creation of emergency medicine as a specialty.

ACTION: The CAS Administrative Board took a strong stand opposing in principle specialty recognition of emergency medicine. The consensus of the Board was that emergency medicine does not represent a body of knowledge or a discipline but rather that it is an occupation.

E. Uniform Application Process for Graduate Medical Education

The idea behind this concept was delineated in the Executive Council Agenda on pages 114-115. This would be a uniform application process for the first year of graduate medical education. Students would be required to complete only one graduate medical application form which could then be reproduced in the Dean's office and distributed to directors of all programs to which the student wishes to apply.

ACTION: Although the CAS Administrative Board took no formal action on this agenda item, it did support the idea to the extent that it could simplify this process for the Dean's office. The stipulation was made that the date issue would need to be flexible.

F. Association of Professors of Medicine Desk at AAMC

Leading off in the discussion of the proposal from the Association of Professors of Medicine (APM) that an APM office be established at AAMC headquarters, Dr. Oliver characterized the proposal as arrogant, simplistic, and naive. It was felt that AAMC represents the interests of all societies and any fragmentation such as this proposal suggested would

threaten the future of the CAS.

Dr. Swanson indicated that a number of CAS organizations, such as the American Federation for Clinical Research (AFCR) and the Endocrine Society, are moving in the direction of hiring professional lobbyists. He suggested that the APM proposal be viewed from the standpoint of when various academic groups, such as AFRC, decide to hire professional lobbyists, whether it would be better to make some accommodation within the environment of the AAMC, to that movement. Dr. Sherman added that the issue to examine was how best to organize this growing phenomenon. The difficulty, as he sees it, is that the route that is being taken is one of increased fragmentation and, therefore, increased competition. He reminded the Board that on the Hill, one hears urging that the voice of health should be unified. The Public Affairs mechanism recently created should enhance the capability of societies in transmitting their concerns to AAMC and in communicating to the societies developing issues that they learn of within AAMC.

Dr. Morgan underscored the problems that have arisen when societies have engaged nonacademic lobbyists. AAMC has in recent years developed a number of individuals who are experts in a number of areas. He saw as a challenge (in the APM proposal) a way to bring the structure of the AAMC and its expertise together with some of the special interests of the societies.

Dr. Clemente brought up the possible risk of justifying the CAS dues structure when, with enough additional money, the society could be identified as a separate group with more influence. One must ask whether it will be the organization with more money which will have more power? Or will it be that the clinical and scientific societies will be represented equally by AAMC?

ACTION: The consensus of the CAS Administrative Board was that further exploration of the APM proposal is justified but that the CAS Administrative Board would need additional information before taking any specific action.

G. Health Manpower Legislation

The CAS Administrative Board discussed at length the problems inherent in the health manpower legislation as it encroaches upon the rights of the medical schools to determine their own admissions policies, curriculum design, etc. Dr. Webster referred to the stand taken by the Council in its action* on November 12, 1974. (See next page)

ACTION: By a majority vote the CAS Administrative Board took action to recommend that the Executive Council reconsider the health manpower legislation and that it go back to the Congress for the purpose of seeking to have the legislation amended to eliminate from it the provisions regarding U.S. foreign medical students. The vote was six for and three against.

III. Discussion Items

A. Retreat Agenda

The CAS Administrative Board reviewed a number of issues that were covered in the Retreat of AAMC Officers. Both the Agenda and the Report of the Retreat were provided to the Board. Among the several items taken up were the following:

1. Relationship of Vice Presidents to AAMC - The officers considered whether AAMC as currently structured has appropriate mechanisms for relating effectively to the Vice Presidents who are found in an estimated 50% of the medical centers. The conclusions reached were outlined in the Report of the Retreat (Page 3, Item III, last paragraph).

2. Housestaff Representation in AAMC - The officers felt that house officers should be included on AAMC committees when appropriate, but decided it was not feasible to establish a house officers group analogous to the OSR.

   Dr. Oliver said he found it paradoxical that AAMC could take a position not to include housestaff when they have taken a position that they are students. As students, he added, housestaff could relate to the OSR. Dr. Webster indicated his willingness to await the legal decision on the status of housestaff before coming to grips with this issue.

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*On November 12, 1974 the Council voted unanimously to support the following action taken by the CAS Administrative Board on September 19:

"The CAS Administrative Board voted unanimously to recommend that the AAMC be advised of the faculty's concern about the portions of the proposed HPEA bill that constrain and impinge upon the integrity of undergraduate and graduate medical education even to recommend the defeat of the total bill. The CAS Administrative Board further recommends that every Dean and every Board of Trustees seek every opportunity to obtain funding through alternative means such as tuition increases, increased support from state legislatures, or a decrease in faculty size where necessary to preserve the role of the medical schools in developing and implementing educational programs."

3. Task Force on Graduate Medical Education - The CAS Administrative Board were invited to suggest possible members for an AAMC Task Force on Graduate Medical Education. This Task Force is estimated to have a life of about two years and would be charged to look at graduate medical education from the standpoint of how the academic medical centers can improve the quality of graduate medical education. Dr. Clemente urged that this effort include as a focus the problems of postdoctorals in the basic medical sciences.

B. Clinical Laboratory Improvement Act

Dr. Morgan reviewed the background of this act. The present status is that DHEW is apparently being urged to write tough regulations under the 1967 authority to control laboratory costs and to demonstrate to Congress that no new authority is needed.

On November 30, 1976, AAMC convened a task force of representatives from 12 societies to discuss ways to provide constructive input to DHEW and to Congress. The task force agreed that where patients are involved, results of clinical research laboratories must be assured by standards at least as stringent as, but different from, those applied to service laboratories. The task force will gather and transmit information to Congressmen, response to the expected DHEW regulations when promulgated, and seek an amendment to the laboratory bill when re-introduced. The proposed amendment would allow the Secretary, DHEW, to deal differently with those research laboratories which also offer some services to patients.

C. CAS Public Affairs Workshop

The CAS Public Affairs Workshop had an excellent faculty and positive participant response. (Participants and organizations they represented were listed in the Agenda.) The next steps will be to identify areas of concern to the societies for policy development and action, and to use these Public Affairs Representatives as effectively as possible.

Dr. Clemente suggested a follow-up to societies that did not send representatives.

D. Annual Meeting

The 1977 AAMC Annual Meeting will address the issue of Graduate Medical Education. A list of topics tentatively proposed for panels was distributed. Dr. Hill complained that concerns of the CAS seemed to be omitted. Dr. Thier suggested as a topic "The Role of Graduate Medical Education in Perpetuating the Academic Community." Dr. Bishop added as a possibility "The Relationship of Graduate Medical Education in the Academic Community or in the Community Setting" (such as community hospitals). An interim report of the Task Force on Graduate Medical Education was suggested.

New formatting will provide an extra one-half day for Council activities.

E. CAS Brief

The purpose of the CAS Brief is to present issues about which CAS society members should have prospective information. It is published quarterly in late January, mid-April, early July, and the last week of September. One dozen societies now distribute to individual members of their society copies of the CAS Brief. Dr. Clemente suggested a follow-up with executive committees of the societies to formulate questions that their memberships would like to see addressed in CAS Briefs during upcoming issues.

IV. Adjournment

The meeting was adjourned at 12:50 p.m.

MHL:ms
3/18/77

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: Ms. Mignon Sample

NAME OF SOCIETY: American Society for Clinical Pharmacology and Therapeutics

MAILING ADDRESS: 1718 Gallagher Road, Norristown, Pennsylvania 19401

PURPOSE: See "Objectives" or page 16 of the Society Directory

OBJECTIVES

The objectives of the Society shall be to promote and advance the science of human pharmacology and therapeutics, and in so doing to maintain the highest standards of research, education, and exchange of scientific information. In its efforts to meet the primary objectives, the Society shall:

A. Stimulate teaching of human pharmacology and therapeutics as a scientific discipline in medical schools and various other academic institutions, as well as participate in educational efforts directed toward the continuing education of practicing physicians.

B. Provide consultation and advice for the better evaluation of the biochemistry, clinical pharmacology, safety, and therapeutic efficacy of drugs and other therapeutic measures.

C. Act as an advisory body to educational institutions, governmental agencies, and such other organizations and bodies as seem indicated and as determined by the Board of Directors of the Society.

D. Provide for additional educational and scientific activities as are deemed necessary by the Society.

MEMBERSHIP CRITERIA: See "Qualification ..." or top of page 17 of the Society Directory

QUALIFICATION FOR MEMBERSHIP

I. MEMBER

(a) shall have earned the degree of Doctor of Medicine or a doctor's degree in any one of the biomedical sciences, or show evidence of its equivalent in experience and performance.

(b) must demonstrate to the Membership Committee his sincere interest in clinical pharmacology and therapeutics . . . and show evidence of achievement through meritorious contributions to the literature.

II. CANDIDATE MEMBER

Non-voting and designed for individuals exhibiting interest in human pharmacology, primarily those in training but who have not yet fulfilled the qualifications for voting membership. This classification will be limited to a period of five years.

Candidate members will be considered by the Membership Committee for advancement to full Membership upon new application to the committee demonstrating additional qualifications.

NUMBER OF MEMBERS: Voting 846, Total 1,023

NUMBER OF FACULTY MEMBERS: Not available

DATE ORGANIZED: May 1, 1900

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

June 20, 1970 1. Constitution & Bylaws

March 18 & 19, 1976 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

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(c)3 and 509(a)

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.

Elmer H. Funk, Jr., M.D.
(Completed by - please sign)

January 10, 1977
(Date)

COUNCIL OF MEDICAL SPECIALTY SOCIETIES LIAISON

In 1976 Richard Wilbur, M.D., became the full-time Executive Vice President of the Council of Medical Specialty Societies. One of his first recommendations to the CMSS was to invite representatives from the parent organizations of the Coordinating Council on Medical Education to participate in the meetings of the CMSS. Gus Swanson has attended two CMSS meetings and in both instances was able to obtain information regarding the views of the specialty societies and exchange information from the floor with representatives to the CMSS. Although Dick Wilbur has not requested a reciprocal arrangement with the AAMC, it might be advantageous to develop closer relationships with the CMSS, which appears to be a growing organization which will have increasing impact on national medical policies in the future.

There are two possible approaches:

1) Invite Dick Wilbur to attend the quarterly meetings of the CAS Administrative Board, beginning at the usual 5:00 p.m. hour on Wednesday, and extending through the luncheon and plenary session on Thursday afternoon. A modification of this approach would be to invite him to the CAS Administrative Board meeting beginning Thursday morning, extending through the plenary session. This would leave the Wednesday evening session clear for the discussion of potentially "sensitive" issues.

2) Invite Dick Wilbur and members of his staff to attend the CAS Annual Meetings. This would be a less direct reciprocation - CAS Annual Meetings are considered open meetings anyway.

The CAS Administrative Board is asked to consider whether or not to reciprocate with CMSS and which of the approaches should be taken.

CONFERENCE CALL ON THE CLINICAL LABORATORY IMPROVEMENT ACT

On February 1, 1977, the AAMC Task Force on Clinical Laboratory Regulation held a conference call to discuss CLIA legislation and comments generated since the Task Force meeting of November 30, 1976. Participating in the conference call were Drs. Kennedy, Morgan, Swanson, and Sherman and Scott Swirling of the AAMC staff; Drs. Benson, Weary, Dibona, Weldon, Trobaugh, Hill, Brasel, Young, Bollet, Ross, Sessions, and Gruppenhoff of the AAMC Task Force.

The discussion began with Dr. Ellis Benson, who is the representative of the Academy of Clinical Laboratory Physicians and Scientists to the Council of Academic Societies, summarizing his reservations about the consensus position established on November 30, 1976. His feelings were: 1) it cannot be assumed that research laboratories always provide to patients laboratory service of adequate quality and reliability, and therefore they should be required to meet the same standards as other clinical laboratories; 2) technology transfer will not be inhibited by the institution of standards for clinical research laboratories; and 3) research laboratories which provide services on a continuing basis should be required to meet the same standards as other clinical laboratories involved in patient care.

The discussion then shifted to the information Dr. Virginia Weldon received in a conversation with Senator Javits' staff counsel, Jay Cutler. Mr. Cutler at the time was revising the Senate version of the Clinical Laboratory Improvement Act, and had included in the draft language the following provision for "pure" and "mixed" research laboratories:

> The Secretary acting through the NIH shall upon application, exempt, on a case-by-case basis on such terms and conditions as may be appropriate to insure the public health, from the national standards for clinical laboratories any laboratory or portion thereof in which the tests or procedures which are performed are tests or procedures primarily for biomedical or behavioral research.

Following this information the discussion focused on what Mr. Cutler's language would mean to the AAMC and its constituency. It was agreed that the Cutler language was quite flexible and thus it is to the AAMC's advantage for the legislation to be written that way. Dr. Jay Bollet summarized this point by stating that there is a great need for the statutory language of the Clinical Laboratory Improvement Act to be simple and general, and that the proper place for explicitness and detail would be in the regulations that would be promulgated by DHEW and NIH.

Agreeing that some sort of control will be placed over clinical research laboratories, either in the legislation itself or in future regulations, the discussion then centered on what kind of controls would be the best, from the points of view of the Congress, DHEW and the AAMC constituency. Dr. Weldon informed the group that Mr. Cutler appeared to be leaning toward some method of output testing as a valid measure of reliability for clinical laboratories, as opposed to the concept of credentialing laboratory personnel. The consensus of the Task Force was that credentialing would be extremely expensive because of increased payroll costs, and would not assure reliability of data and therefore was opposed by the Task Force. While there was support for the concept of output testing, several questions were raised concerning the parameters and methodology of assuring reliability and validity of clinical laboratory tests.

There was agreement, however, that whatever method of assuring reliability in clinical research laboratories was ultimately selected, it should be administered on the local level as opposed to national controls administered by an organization or agency in Washington. There was also agreement that the system employed should be similar to either the system of institutional review bodies overseeing biomedical and behavioral research projects involving human subjects, or to the system utilized by the Nuclear Regulatory Commission in which the NRC has spelled out the conditions of use of radioisotopes and radiation devices but where the local safety committees have broad latitude in applying these regulations to local laboratories and treatment units.

Dr. Morgan was requested to assess the possibility of recommending the N.R.C. system to the Congress as an analogue to the method that should be established for overseeing clinical research laboratories The AAMC staff was also requested to continue to work with the committee staff in developing the legislation and the language for Mr. Javits' introductory statement.

Subsequent to the conference call on February 10, 1977, Senator Jacob Javits introduced S.705, the Clinical Laboratory Improvement Act (CLIA) of 1977. The bill, which has been referred to the Committee on Human Resources, has been cosponsored by nineteen Senators, including Senator Edward Kennedy, Chairman of the Subcommittee on Health of the Committee on Human Resources. A companion bill will be introduced into the House of Representatives within the next two weeks by Representative Paul Rogers, Chairman of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce.

CLIA 1977 is substantially similar to the bill approved by the Senate on April 29, 1976 and which failed to pass the House of Representatives in the final days of the 94th Congress. The purpose of this bill is to insure that laboratories soliciting and accepting specimens

for laboratory analysis meet quality assurance standards and to prevent fraud and abuse in laboratories. During consideration of CLIA 1976 during the 94th Congress, the AAMC expressed to Senator Javits, Representative Rogers, and their staffs, the concern that the enactment of that legislation would have a serious, harmful effect upon the operations of clinical laboratories whose major or sole activity is biomedical research. The AAMC urged that some limited or total exemption from the requirements of the bill be included for these clinical research laboratories. S.705 does include such an exemption: The bill would amend Section 353 of the Public Health Service Act to read, in part,

> "Sec. 353(c)(2)(D)(iv) The Secretary shall, upon application, exempt, on such terms and conditions as may be appropriate, from the national standards for clinical laboratories any laboratory in which the tests or procedures which are performed are primarily tests or procedures for biomedical or behavioral research."

In his statement accompanying the introduction of S.705, Senator Javits included a paragraph, drafted by Tom Morgan, that further explains this provision of the bill:

> "From these laboratories have come many of the recent important advances in the diagnosis of disease, and that process should be encouraged in every way consistent with the public welfare and safety. Since the time of the Senate passed bill, attention has been called to the special requirements of these research laboratories. Frequently staffing patterns and educational background of personnel are different in research laboratories; therefore the Senate passed bill might have inhibited the transfer of their research-proven ideas to clinical diagnosis and care. The bill I introduce requires the Secretary to formulate special procedures for the regulation of those clinical laboratories which engage in biomedical and behavioral research so that they may continue their vital function."

If this bill becomes law, the regulations to be written by the Secretary to enforce Sec. 353(c)(2)(D)(iv) will have to include 1) a precise definition of the word "primarily;" 2) a procedure by which clinical research laboratories may apply for an exemption from the requirements of the law; and 3) an alternate regulatory procedure for those laboratories granted an exemption.

CLINICAL FELLOWS TRAINING STUDY - PROGRAM REPORT

The National Research Council of the National Academy of Sciences has an ongoing responsibility to study personnel needs and training for biomedical and behavioral research. This year the AAMC has been asked to contribute to this effort by providing special detailed studies on research fellows and other physician trainees in the clinical sciences to the Advisory Panel on Clinical Sciences. This Panel will incorporate the AAMC study in its report to its parent body, the Committee on a Study of National Needs for Biomedical and Behavioral Research Personnel (known also as the Glaser Committee after its Chairman, Dr. Robert J. Glaser).

In the brief time period available for this study, the AAMC has been examining data from three types of sources to provide the needed information:

A) Nationally conducted surveys: Principal among these sources are the 1976 Council of Teaching Hospitals Questionnaire and the 1975 National Survey of Teaching Hospitals conducted by the Institute of Medicine. Attachment 1 shows a comparison of the two sources on the number of advanced clinical trainees and their distribution by specialty. Also available through the IOM study were data on the professional activities of fellow and advanced resident trainees. Attachment 2, which was reported to the Panel in late January, is a brief description of the research activities of such trainees.

B) Special studies conducted by individual specialty societies and professional associations: This is the final section of the study and work will be undertaken in June. Your advice as to organizations which may have useful information would be most appreciated.

C) AAMC Institutional Study Group: The AAMC has been working through a small network of academic health centers of different characteristics with respect to number of trainees, ownership, research involvement, and geographic location. These centers have provided an opportunity for a detailed study of their clinical research training activities and changes which have occurred in the period from 1972 to the current academic year. Our relationship with these centers has provided information on the lack of homogeneity in today's pool of clinical research trainees--from differences in the trainee's academic preparation, in what they are called, in how they are supported, and in the mix of professional activities which comprises their training experience. Lengthy interviews with administrative, departmental and hospital personnel have also provided insights on a number of pertinent issues which will be included in our initial report to the Panel next week:

1) Payback provisions: Program directors regard payback provisions as beneficial insofar as they serve as a deterrent to those who are not seriously considering an academic career, and because most trainees can meet the provisions by clinical service. Certain criticisms articulated include:
   --lack of understanding of the magnitude and implications of the provisions by both potential trainees and program directors
   --inequity of the program for Ph.D.'s
   --forms a disincentive for the inexperienced to try research
   --forces research failures to continue in research

2) Program instability: The solicitation and grant funding cycles impose a burden of uncertainty and instability on participating programs and their trainees. This has been somewhat intensified in recent years by the experience of many training programs that support for their activities must be solicited from several sources, many of which are also being approached by other medical schools and hospitals.

3) Clinical experience: Although many of the clinical research programs feel that their trainees must acquire certain direct clinical experiences and skills before research projects can be successfully undertaken, support for the clinical elements of the research training period is difficult to secure.

4) NIH Role: There appear to be discrepancies and misconceptions about the numbers of trainees supported by the National Institutes of Health and the proportion of the total funding amount which comes from that source.

5) In addition to their concerns about uncertain funding for research training programs, many fellows feel that there are diminishing prospects for productive academic careers.

As part of its preliminary report to the Panel, the AAMC also proposes to outline a number of clinical training issues which warrant additional research attention. Your suggestions in this area would be helpful to the staff.

Attachment 1

NUMBER AND DISTRIBUTION OF ADVANCED TRAINEES BY SPECIALTY

	1976-77 COTH Report*		1974-75 IOM Survey**	
	Number	Percent	Number	Percent
ALLERGY	75	.7	68	.6
ANESTHESIOLOGY*	236	2.4	154	1.4
DERMATOLOGY*	67	.7	60	.5
FAMILY/GENERAL PRACTICE	13	.1	28	.3
INTERNAL MEDICINE	892	8.9	2,401	21.6
Cardiology	1,142	11.4	497	4.5
Endocrinology/Metabolism	317	3.2	129	1.2
Gastroenterology	569	5.7	246	2.2
Hematology	455	4.5	175	1.6
Infectious Disease	269	2.7	118	1.1
Neoplastic Disease/Oncology	207	2.1	117	1.1
Nephrology	475	4.7	185	1.7
Pulmonary Disease	544	5.4	222	2.0
Rheumatology	244	2.4	62	.6
All Other Internal Medicine	189	1.9	42	.4
NEUROLOGICAL SURGERY	56	.6	242	2.2
NEUROLOGY	145	1.4	127	1.1
Child Neurology	39	.4	9	.1
OBSTETRICS/GYNECOLOGY	207	2.1	388	3.5
OPHTHALMOLOGY*	222	2.2	174	1.6
ORTHOPEDICS*	141	1.4	516	4.6
OTOLARYNGOLOGY*	67	.7	213	1.9
PATHOLOGY (All Types)	197	2.0	591	5.3
PEDIATRICS	424	4.2	630	5.7
Cardiology	108	1.1	86	.8
All Other Pediatrics	553	5.5	332	3.0
PHYSICAL MED.& REHABILITATION*	24	.2	15	.1
PLASTIC SURGERY	103	1.0	214	1.9
PSYCHIATRY	177	1.8	254	2.3
Child Psychiatry	288	2.9	284	2.6
RADIOLOGY (All Types)	184	1.8	371	3.3
NUCLEAR MEDICINE*	41	.4	40	.4
SURGERY	468	4.7	1,411	12.7
Cardiovascular/Thoracic Surgery	330	3.3	277	2.5
Pediatric Surgery	63	.6	13	.1
All Other Surgery	218	2.2	13	.1
COLON/RECTAL SURGERY*	18	.2	22	.2
UROLOGY*	57	.6	307	2.8
ALL OTHER PROGRAMS*	218	2.2	90	.8
TOTAL	10,042		11,131	

*Based on a survey of 402 COTH members, with a 94% response rate

**Based on a survey of 1,267 teaching hospitals with a 70.1% response rate

Attachment 2

RESEARCH TRAINEES

In 1975 the Institute of Medicine conducted a survey of house officer activities in 96 teaching hospitals. Log diaries were collected from 1,123 "senior" residents (4th year and above) and 628 fellows. Thirty-five percent of the respondents indicated that they performed some research activities. This was 22 percent of the "senior" residents and 58 percent of the fellows.

Table 1. Percent of Total Respondents Participating in Research Activities by Level of Training and by Specialty

Specialty	"Senior" Residents (1,123) Number	% of total	Fellows (628) Number	% of total
Medical Specialties	27	19.9	230	59.4
Pediatrics	7	21.2	70	60.3
Psychiatry	25	24.2	19	43.2
Surgical Specialties	135	23.2	25	55.6
Others	53	19.7	22	61.1
TOTAL	247	22.0	366	58.3

Of the 613 trainees engaged in research, 40 percent were "senior" residents and 60 percent were fellows. The specialty distribution of these research trainees follows.

Table 2. Distribution of Research Respondents by Level of Training and by Specialty

Specialty	"Senior" Residents Number	Vertical %	Fellows Number	Vert.%	Cum.%
Medical Specialties	27	10.9	230	62.8	62.8
Pediatrics	7	2.8	70	19.1	81.9
Psychiatry	25	10.1	19	5.2	87.1
Surgical Specialties	135	54.7	25	6.8	93.9
Others	53	21.5	22	6.0	99.9
TOTAL	247	100.0	366	99.9	

N.B. The distributions of research trainees by specialty were similar to the specialty distributions for all "senior" resident and fellow respondents.

Attachment 2

Although the majority of "senior" residents engaged in research activities were in surgical training programs, such trainees, on the average, spent a smaller proportion of their professional time in research. In the fellowship years, however, surgical trainees had a higher mean percentage of time in research than did other specialties. Except in psychiatry, research fellows in each specialty spent a greater proportion of their time in research than did "senior" residents.

Table 3. Mean Percentage of Time Spent in Research Activities by Level of Training and by Specialty

Specialty	"Senior" Residents	Fellows
Medical Specialties	29.47	45.07
Pediatrics	28.00	44.91
Psychiatry	30.61	21.68
Surgical Specialties	18.77	67.56
Others	33.08	46.17

The survey respondents were able to indicate joint activities on their log diaries. The only significant joint product in the research area was research/patient care. Approximately seven percent of the research respondents performed research only in conjunction with patient care. Seventy-eight percent of the research respondents performed only "pure" research activities. This means that 27 percent of the total respondents engaged only in pure research activities and three percent performed only research/patient care functions.

MEDICAL FACULTY STUDY - PROGRESS REPORT

A section of a major AAMC study funded by the National Institutes of Health on the development of medical faculty concerns various forms of peer evaluation of faculty performance in research activities. As part of the effort to understand and document these largely unwritten evaluation criteria, the AAMC asked for the cooperation of the CAS Administrative Board in a project to rank criteria for the evaluation of clinical and basic science faculty researchers.

The results of your participation are still being received, and will be analyzed and presented for your review at the meeting. Additionally, the AAMC is interested in your reactions to the experiment and suggestions for its further refinement and application.

At the meeting there will also be an opportunity to discuss the next phase of the peer evaluation study which plans a more detailed examination of one specific measure of peer evaluation -- faculty advancement -- with other measures of research performance available through the NIH.

CONFERENCE CALL ON THE RENEWAL OF BIOMEDICAL RESEARCH STATUTES

On January 27, 1977, a conference call between the AAMC staff and the CAS Administrative Board was held to discuss: a) the AAMC position concerning the renewal of the authorities for the expiring legislation, and b) how best to inform the Congress of the AAMC position. The staff, eager to arrive at a decision quickly in order to inform the Congress before legislation was introduced, requested that the CAS Administrative Board take the lead in determining the AAMC position. Participating in the conference call were Drs. Kennedy, Morgan, Swanson and Sherman, and Scott Swirling of the AAMC staff; Drs. Bollet, Braunwald, Clemente, Eggers, Hill, Swan and Thier of the CAS Administrative Board.

The statutes under discussion were the National Cancer Act of 1971 (P.L.92-218) as revised and extended by the National Cancer Act Amendments of 1974 (P.L.93-352); the National Research Service Award Act of 1974 (P.L.93-348) and the authority of the National Heart, Lung and Blood Institute component of the National Institutes of Health, as revised and extended by the Health Research and Health Services Amendments of 1976 (P.L.94-278); and the National Health Planning and Resources Development Act of 1974 (P.L.93-641). The main point under discussion was whether the AAMC should support a one or three year renewal of these statutes. There was virtually unanimous support at the outset for the one-year renewal. This position was engendered for the following reasons:

1) Both Senator Edward Kennedy and Representative Paul Rogers, Chairmen of the Senate and House Health Committees respectively, have indicated that general oversight hearings will be held during 1977 on federal support of biomedical and behavioral research and on the mission and accomplishments of the National Institutes of Health. These hearings will give the Congress the opportunity to consider at length issues surrounding NIH and biomedical and behavioral research, and a one year renewal would permit these programs to continue to operate until a more thorough evaluation could be conducted.

2) The Carter Administration has indicated that it would prefer a one-year renewal of all expiring authorities so that it can study as fully as the Congress the status of federal biomedical and behavioral research programs before developing its priorities.

3) A one-year renewal coupled with an overall evaluation of the programs concurs with the recommendations of the President's Panel on Biomedical and Behavioral Research.

4) A one-year renewal of the Health Planning Act will give the Congress time to conduct a thorough evaluation of that Act and to consider major substantive changes that are likely to be proposed.

Although an agreement was reached that the AAMC's position ought to be to recommend to the Congress a one-year renewal of these statutes, certain conditions were placed upon that agreement. Dr. Braunwald at first opposed the one-year renewal and wanted a renewal package for three years. His concern was that a one-year renewal would simply continue the authorities without any changes, including the levels of appropriation authorizations. Thus it was decided that the AAMC recommendation of a one-year renewal should include the stipulation that appropriate increases must be made in the appropriation authorization levels. Without such increases, it was noted, the programs involved (particularly those in the area of heart and lung research) would be seriously underfunded.

The decision to recommend a one-year renewal was based partially on the implications of a three-year renewal. A three-year renewal of any of these programs, but particularly the cancer and heart programs, might well result in an entire review of the NIH at a time when there could be serious consequences. Moreover, a three-year renewal of the cancer and/or heart and lung programs might also escalate the pressures for more "disease of the year" programs, a syndrome to which the Association is totally opposed. Thus, it was felt that the AAMC could better articulate its position during future Congressional oversight hearings rather than during hearings on the renewal legislation which would of necessity be conducted under severe time constraints.

The decision was made to send a letter to Senator Kennedy and Representative Rogers informing them of the Association's recommendations and incorporating the supporting arguments discussed during the conference call. Copies of those letters, which were sent out on January 31st, are attached.

January 31, 1977

Honorable Edward M. Kennedy
Chairman
Subcommittee on Health
Committee on Labor and
Public Welfare
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

The authorizing legislation for several major federal health programs is due to expire during 1977. Among these statutes, and of most concern to the Association of American Medical Colleges and its constituency, are the National Cancer Act of 1971 (P.L. 92-218) as revised and extended by the National Cancer Act Amendments of 1974 (P.L. 93-352); the National Research Service Award Act of 1974 (P.L. 93-348) and the authority of the National Heart, Lung and Blood Institute component of the National Institutes of Health, as revised and extended by the Health Research and Health Services Amendments of 1976 (P.L. 94-278); and the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

In anticipation of the expiration of this legislation, extensive discussion has taken place in the biomedical research and academic communities concerning the course of action these communities hope the Congress will take in 1977 in renewing and revising these programs. The Association believes that a one year renewal of the above mentioned authorities, with appropriate technical and fiscal authorization changes, would be most desirable. Our reasoning in support of this position is as follows.

Both you and Representative Paul Rogers, Chairman of the House Interstate and Foreign Commerce Subcommittee on Health and the Environment, have indicated that general oversight hearings will be held during 1977 on federal support of biomedical and behavioral research on the mission and accomplishments of the National Institutes of Health. These hearings would give the Congress and opportunity to consider at length issues surrounding the NIH and biomedical and behavioral research. A one year renewal accompanied by appropriate adjustments in the authorized appropriations levels of the cancer, heart, lung and blood, and the research training programs would permit these programs to continue to operate at their high level of excellence until a more thorough evaluation of their place in the overall federal biomedical and behavioral research

effort could be concluded. Such an overall study coupled with a one year renewal would be in full accord with the recommendations of the President's Panel on Biomedical and Behavioral Research.

In addition, it is reasonable to expect that the New Administration of President Carter will wish to study as fully as the Congress the status of federal biomedical and behavioral research programs. A renewal for one year of the expiring programs would provide the Administration time needed to conduct a thorough evaluation and establish its priorities.

In Attachment I are tabulated reasonable interim authorizations which would permit acceptable levels of operations pending completion of the contemplated comprehensive review of these programs.

The Association also supports a one year renewal with technical changes of the Health Planning Act while the Congress conducts a thorough evaluation of this statute. We hope, however, that during this next year the Congress will carefully consider amending the law to include a provision requiring representation from academic medical centers on the executive committee (if any) of all local health systems agencies. Such a requirement would provide academic medical centers the opportunity to fully participate in and contribute to the establishment of policies which could have direct and important impact upon their operations. These centers constitute major resources for health care in all HSAs in which they are located and the communities should have assured access to the insight, knowledge and wisdom which they encompass. Further, the AAMC would urge that the law be amended to exempt from Health Systems Agencies review and approval the usage of federal funds for research administered under NIH grants and contracts. Obviously, consideration of these changes in the law, and other major substantive changes that are likely to be proposed, should not be undertaken hastily. A one year renewal of the Health Planning Act will provide the time necessary for a competent review of the entire statute unfettered by time pressures and constraints.

The Association of American Medical Colleges would appreciate your favorable consideration of our recommendation in support of a one year renewal of these programs, and I and my staff stand ready to assist you in any way in which we can be helpful.

Sincerely,

Original signed by
J. A. D. COOPER, M.D.

John A. D. Cooper, M.D.

Attachment

PROGRAM	AUTHORIZATIONS IN MILLIONS Actual FY 1977	Suggested FY 1978
National Cancer Institute	1073.5	1100
National Heart, Lung & Blood Institute	403	550
National Research Service Awards	185	250
Health Planning Act:		
Planning and regulation;		
Health systems agency planning grants, Sec. 1516.....	125	185
State health planning and development agency grants, Sec. 1525.....	35	45
Demonstration grants for regulation of rates for health services. Sec. 1526..	6	7
Centers for Health Planning-grants or contracts, Sec. 1534.....	10	13
Subtotal.....	176	250
Resources development:		
Health facilities construction and modernization allotments and grants, Sec. 1613.....	135	170
Health facilities construction and modernization loans and loan guarantees, Sec. 1622.....	Such sums as may be necessary	
Development grants for area health services development funds, Sec. 1640.....	120	150
Subtotal.....	255	320
Grand total.....	431	570

AAMC 1/77

aamc association of american medical colleges

March 15, 1977

TO: Officers and Representatives, Academic Societies, and Council of Academic Societies Administrative Board, and CAS Public Affairs Representatives

FROM: Thomas E. Morgan, M.D. and August G. Swanson, M.D.

SUBJECT: 1977 Interim Meeting of CAS

During 1976 a series of meetings were held between officers of constitutent academic societies and staff of the Association. One consensus of these discussions was that the interim meetings of CAS be held in two or more sections at different sites and that the format be that of informal information exchange and questions and answers (resembling the format of the June and September, 1976, meetings).

The CAS Administrative Board has requested that at least one of the 1977 meetings be held in conjunction with the Administrative Board meeting. Accordingly, we are scheduling a one-day meeting of CAS representatives and/or officers, CAS Administrative Board members and AAMC staff at the Washington Hilton on Wednesday, June 22, 1977. The meeting will begin late enough in the day so that most representatives can attend without an overnight stay. (The CAS Administrative Board meeting will follow on Wednesday evening and Thursday morning).

A second meeting will be held later in Chicago or the west. Further details will follow but those who are interested in attending the June meeting should MARK THEIR CALENDARS NOW.