aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel

June 13, 1979

| | | |
|---|---|---|
| 5:00 p.m. | Business Meeting | Jackson Room |
| 6:30 p.m. | Joint Boards Social Hour | Thoroughbred Room |
| 7:30 p.m. | Joint Boards Dinner in honor of Dr. John A. D. Cooper's tenth anniversary as AAMC President | Thoroughbred Room |

June 14, 1979

| | | |
|---|---|---|
| 9:00 a.m. | Business Meeting (Coffee and Danish) | Grant Room |
| 1:00 p.m. | Joint CAS/COD/COTH/OSR Administrative Boards Luncheon | Hemisphere Room |
| 2:30 p.m. | Adjourn | |

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 13-14, 1979

IV. INFORMATION ITEMS

# MINUTES
# COUNCIL OF ACADEMIC SOCIETIES
# ADMINISTRATIVE BOARD

March 28 - 29, 1979

Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members

Thomas K. Oliver, Jr.
Chairman (Presiding)
Robert M. Berne
F. Marian Bishop
Carmine D. Clemente
G. W. N. Eggers, Jr.
T. R. Johns
Virginia V. Weldon
Frank C. Wilson, Jr.

Staff

Judy Braslow*
John A. D. Cooper*
Lynn Gumm
Thomas Morgan
Diane Newman-Plumb
John Sherman*
August Swanson

ABSENT:

David M. Brown
Daniel X. Freedman
James B. Preston
Samuel O. Thier
Frank E. Young

Guest: Charles B. Womer

The CAS Administrative Board Business Meeting convened on March 28, 1979 at 4:30 p.m. and adjourned at 5:30 p.m. A joint session was then held with the other administrative boards for a presentation from James Mongan, Director, Office of Planning and Evaluation, Office of the Assistant Secretary for Health. Following Dr. Mongan's presentation, the Administrative Boards reassembled for cocktails, followed by dinner at 8:00 p.m. The Business Meeting reconvened at 9:00 a.m. on March 29, 1979. Following the usual custom, the CAS Administrative Board joined the other AAMC Boards for a joint luncheon meeting at 1:00 p.m.

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*present for part of the meeting

I. Adoption of Minutes

The minutes of the January 17-18, 1979 CAS Administrative Board Meeting were approved with the deletion of the word "one" in the fifth sentence of Part B on page 3.

II. Executive Council Action Items

A. Proposed Revision to CAS Rules and Regulations

Dr. Oliver informed the Administrative Board that the proposed revision to the CAS Rules and Regulations which appeared as an Action Item on the Executive Council Agenda had been approved at the CAS Interim Meeting. He briefly reviewed the discussion that had taken place at that meeting and stated that he would urge the Executive Council's approval of the revision.

B. Report of the CCME Committee on Opportunities for Women in Medicine

Judy Braslow was present to discuss the Committee's January 4, 1979 draft report. She was not enthusiastic about the report stating that it was not well-written and was based on out-dated information. However, in spite of these concerns, Ms. Braslow expressed the opinion that an inordinate amount of time had been devoted to the report already and, since its basic thrust and recommendations were acceptable, she recommended that no additional effort be expended. She reviewed a list of specific editorial changes AAMC would propose to make the report minimally acceptable.

ACTION: The CAS Administrative Board voted unanimously to approve the January 4, 1979 draft report of the CCME Committee on Opportunities for Women in Medicine on the condition that the Committee effect the specific modifications recommended by the AAMC.

C. Meeting of House Staff on Graduate Medical Education Task Force Report

Dr. Oliver gave background information on the issue of house staff representation to the AAMC. An ad hoc committee on House Staff Involvement with the AAMC, chaired by Dr. Thier, had determined that a national conference of residents should be sponsored by AAMC and that this mechanism for achieving house staff input would be preferable to establishing a permanent house staff council or group within the AAMC. After reviewing the ad hoc Committee report, the AAMC developed a proposal for organizing such a meeting. The proposal recommended that thirty housestaff participants be selected from nominations submitted by the deans and the OSR. Each dean would be asked to submit three nominations, and the OSR would be asked to nominate one resident from each specialty. The proposal further recommended that the meeting agenda be coordinated around the report of the Graduate Medical Education Task Force Working Groups. Dr. Oliver stated that the OSR had raised objections to this proposal which would be discussed at the Executive Council meeting.

Essentially, the OSR felt that they should have more input regarding the organization of the meeting and that they should play a more major role in determining who would participate in the Conference. The OSR also felt it would be appropriate to have an open agenda for discussion of several different topics. The CAS Board discussed the OSR's objections as well as the wisdom at this juncture or in the future of an AAMC house staff council or group. The concept of incorporating house staff representation within CAS was also briefly discussed. The Board agreed with the conference approach as the most appropriate means of seeking house staff input to the Association at this point in time. It was also agreed that an open agenda would not be prudent as the discussion would probably focus on issues concerning house staff economic and working conditions.

ACTION: The CAS Administrative Board endorsed the concept of sponsoring a house staff meeting on the Graduate Medical Education Task Force Report and approved the staff recommendations for format and participant selection.

III. Executive Council Discussion Items

A. Advanced Placement Achievement Test

Dr. Swanson provided background information on the National Board of Medical Examiners' proposal to develop an examination to assess the ability of students applying for advanced placement in U.S. medical schools. This exam would be given in place of the Part I Exam now being given by the NBME. Dr. Cooper was present during the discussion of this proposal and asked that the Board consider whether the AAMC should be involved in the development or sponsorship of the exam, whether or not such an exam is even necessary, and if so, how the content should be determined.

The Board discussed the concept of an advanced placement achievement test and agreed that it would be useful for the schools to have the results of such a test for the assessment of all advanced-standing applicants. It was also agreed that NBME should develop and sponsor the test but that AAMC might play an advisory role in determining content and might be involved in registering candidates and reporting scores. It was felt that if an advanced placement achievement test is developed, it should be vigorous and broad in scope. The Board also stressed that the purpose of the exam should be to provide medical schools with information as to the capability of candidates for advanced standing and that it should not be perceived as the first step in the certification process. It was agreed that scores, rather than a pass/fail designation, should be provided and that a national passing score should not be established. It was also agreed that the exam should be open to anyone wishing to take it including individuals not previously enrolled in medical school and that efforts should be made to avoid the connotation of a "transfer" or "screening" exam.

B. Proposal for FLEX I & II Examinations

Dr. Swanson explained that the Federation of State Medical Boards is proposing that a new system of two FLEX examinations be instituted. FLEX I would be administered prior to entry into graduate medical education and passage of the exam would entitle an individual to licensure for practice under supervision in a residency training program. FLEX II would qualify an individual for an unrestricted license and could be taken after at least one year of residency training. The pros and cons of the proposed system were discussed. It was the sense of the Board that it would be disadvantageous and inappropriate for the FSMB to play the role of "gatekeeper" of graduate medical education. The extent to which medical schools will be obligated to students who fail to pass the exam was another potential complication which was discussed. The Board concluded that the Liaison Committee on Graduate Medical Education and not a licensure body would be the appropriate agency to develop and implement a test to measure the ability of students entering graduate medical education.

C. VA Budget

Dr. Morgan informed the Board that several representatives of the AAMC staff and Executive Council had attended a meeting with VA officials for a discussion of the proposed FY 1980 VA budget. The main topics discussed relating to the proposed budget were the cutbacks in VA personnel which would be necessitated and the decline in support for medical education, medical research, and various new initiatives in areas of special interest to the Veterans Administration. Dr. Morgan stated that the AAMC is particularly concerned about the inadequate funding levels requested for research and medical education. Extension of the VA program of assistance to health manpower training institutions beyond September 30, 1979 is not proposed by the Carter Administration and therefore, no appropriation was requested for the coming year. The AAMC is recommending that the program be continued and that it be funded at the level of $50 million in FY 1980. The AAMC is faced with somewhat of a dilemma this year because the VA Administrator and Medical Director seem willing to accept President Carter's proposed budget as inevitable in these times of reduced federal spending. Therefore, the AAMC may be in the tenuous position of recommending additional funds for an agency which is willing to accept what has been recommended.

Those present at the meeting also learned of a five-year no-growth plan for housestaff positions. It is proposed that 100-150 positions a year for the next five years be transferred from established programs to emerging programs. A decline in support of investigators of various types is anticipated if this plan is put into effect.

D. Proposed Revision of the General Requirements

Dr. Swanson reviewed the points discussed in the CAS small group discussion at the Interim Meeting on the proposed revision of the

General Requirements. The major discussion at that meeting and the main concerns raised in other forums related to requirements for training programs in the newly-designated program types--categorical and transitional. There has been ambivalence expressed within internal medicine about the requirement that transitional programs only be offered in institutions which have an accredited internal medicine program. While internal medicine perceives the importance of all transitional residents gaining a knowledge and experience base in medicine, there is concern that this requirement will place further stress on internal medicine's resources for training residents destined for other specialties. In addition, there is concern about the requirement that categorical programs in specialties which require complimentary educational experiences in other specialties must assure that those experiences are provided in an accredited program. In some instances, the most valuable complimentary experience might be gained in an unaccredited program. To address this concern, a modification might be recommended to allow each RRC to indicate in its Special Requirements whether related experience must be in an accredited program. Dr. Swanson indicated that the General Requirements will be discussed at the May 24 CCME Meeting, and he requested Board members to communicate further comments or suggestions on the revisions to him prior to that meeting.

## IV. Discussion Items

### A. CAS Interim Meeting Follow-Up

Dr. Oliver reported that the Interim Meeting had been quite successful and that positive feedback had been received from participants. He noted that 35 of the 67 CAS societies had been represented by approximately 50 individuals. He reviewed the events of the meeting and provided a brief summary of Dr. Alvin Tarlov's presentation concerning the work of the Graduate Medical Education National Advisory Committee (GMENAC).

Dr. Oliver stated that two resolutions had been approved by the Council at the meeting. The first was proposed during the course of the Workshop on Specialty Distribution by Dr. David Skinner, representative of the Society of Surgical Chairmen. He proposed, and after discussion, the Council resolved that:

> "In view of the progress made by the Graduate Medical Education Task Force and its Working Group on Specialty Distribution, the Council of Academic Societies recommends to the AAMC Executive Council that the Working Paper on Specialty Distribution developed as an interim report not be used by the AAMC in its public testimony or as an Association position."

The second resolution evolved out of a discussion at the Council's Business Meeting on the subject of the lack of continuity of representation to CAS. Dr. Harold G. Jacobson, representative of

the Society of Chairmen of Academic Radiology Departments, proposed and the Council resolved that:

> "The Council of Academic Societies Administrative Board, by whatever means necessary, should urge upon CAS member societies that continuity of representation be stressed."

The Board briefly discussed the two resolutions and Dr. Oliver stated that he would report the resolution on specialty distribution to the Executive Council at this meeting.

B. AAMC Annual Meeting Plans

Dr. Swanson reviewed the customary scheduling procedure for the CAS Annual Business Meeting. Several CAS Representatives have expressed the concern that only one CAS session has not allowed sufficient time for discussion of key issues, thereby limiting the amount of exchange between the Council and the AAMC staff. Several possible alternatives for the scheduling of the meeting were discussed. The Board agreed that the most appealing suggestion was to return to the Interim Meeting format of small group discussions followed by a Business Meeting the next day. It was suggested that the attendance at these small groups might be improved if they were staggered throughout one day instead of conducted simultaneously. It was decided that it would be preferable to meet on Sunday for small group discussions and then reconvene for a speaker, followed by cocktails and dinner which would be covered by a registration fee. The CAS Business Meeting would be held as usual on Monday afternoon.

Several suggestions were made as to topics for the discussion groups including problems in clinical research, problems in basic research, the support of medical education, the declining availability of funds for research training, specialty distribution, competency testing, and the compensation of human research subjects.

C. Compensation of Human Subjects

Dr. Oliver asked Dr. Weldon to brief the Board on the status of developments related to the compensation of human subjects. On March 9, Dr. Weldon had attended a meeting on this subject with HEW officials, representatives of the insurance industry, and other representatives of the AAMC. Dr. Weldon gave a brief history of the issue, beginning with the formation in 1975 of a 12-member HEW task force to study the problem of injured research subjects. Unfortunately, the task force had received virtually no input from the academic medicine community and only one of its members was actively conducting research. The final report of the Task Force was issued in January 1977 but was not publicaly available until the summer of 1978. As a result of the Task Force Report, HEW issued an Interim Final Regulation in November 1978 requiring that, effective January 3, 1979, informed consent statements indicate whether compensation is available to research subjects in the event of injury, the nature of the compensation provided, and where further information can be

obtained. Dr. Weldon stated that some institutions are simply not complying with the regulation because they are at a loss as to how to do so.

Dr. Weldon reported that insurance representatives, clinical researchers, and others have argued vigorously with HEW representatives that the interim regulation and their future plans to require compensation are ill-conceived and will seriously threaten biomedical research. Dr. Weldon indicated that a pervasive and troubling theme in the Task Force Report and in conversations with HEW is the concept that the federal government must control research using cost factors related to compensation as a means of policing high-risk research. Dr. Weldon indicated that HEW seems not to be concerned with how institutions will obtain insurance or how institutions will fund such insurance.

The Board discussed this issue at length and suggested that a prestigious delegation of representatives from major medical centers might be formed to discuss this matter directly with Secretary Califano. It was the Board's opinion that Califano should be informed that the HEW Task Force had not sought or obtained reasonable, thoughtful advice on all aspects of this issue. It was mentioned that litigation against DHEW might be a last-resort approach if all other approaches fail to solve the many problems associated with compensation for human subjects. Dr. Morgan informed the Board that a meeting of AAMC and insurance representatives was scheduled for April to explore possible strategies and that the Board's suggestions would certainly be kept in mind.

D. New Developments in Confidentiality

Dr. Morgan reviewed some of the difficulties research scientists have had in safeguarding their ideas since the passage of the Freedome of Information and Privacy Acts almost five years ago. This problem has been a concern of the AAMC but had not previously generated much interest in the Congress or at NIH. However, recently NIH has been confronted with the problem of industrial concerns utilizing the Freedom of Information Act to obtain information about recombinant DNA research. In order to protect research protocols, NIH is seeking legislative remedy in the form of a modification of the Freedom of Information Act. The AAMC's position has been that a modification of the Public Health Service Act specifically targeted at the protection of research ideas would more efficiently address the problem and avoid the creation of an enormous loophole in the Freedom of Information Act. The Board agreed that this would be the most realistic approach.

E. Clinical Laboratory Improvement Act of 1979

Dr. Morgan informed the Board that the third version of the Clinical Laboratory Improvement Act had been introduced by Senator Jacob Javits on March 9, 1979. He explained that the Javits bill is different from its two predecessors in that it appears to be more of a

laboratory "control" rather than a laboratory "improvement" measure. The current version of the bill also seeks to regulate laboratory tests performed by physicians practicing in groups of six or more. Hearings on CLIA were held by the Subcommittee on Health and Scientific Research on March 16. Among those testifying was Dr. Peyton Weary, CAS Public Affairs Representative for the Association of Professors of Dermatology, Inc. Dr. Weary proposed that the scope of the bill be limited to the 30 most frequently performed laboratory tests. Dr. Morgan noted that the Subcommittee had marked up the bill on March 21; however, a revised version of the bill was not yet available.

Dr. Morgan stated that AAMC had contemplated establishing an ad hoc committee on CLIA made up of representatives from CAS, COD, and COTH. Issues that such a committee might consider would be the removal of the word "biophysical" from the bill, the licensing of institutions rather than individuals to perform laboratory tests, the advisability of regulating physicians in private practice regardless of the size of their groups, and the possibility of the AAMC supporting Dr. Weary's 30-test proposal. The Board discussed these issues at length and agreed that an ad hoc committee would be appropriate. Dr. Oliver stated that he would take this suggestion to the Executive Council.

F. Proposed Changes to the Health Manpower Act Pertaining to Preventive and Community Medicine

The Board was given information pertaining to changes which the Association of Teachers of Preventive Medicine plans to request when the health manpower law is renewed. The present Health Manpower Act authorizes grants to Departments of Community and Preventive Medicine in Schools of Public Health. However, approximately 80 of the 91 community medicine programs in the country are in medical schools and are, therefore, not eligible for such grants. ATPM is proposing that the language of the bill be changed from "schools of public health" to "schools of medicine, dentistry or osteopathy." The Board discussed this proposal and the fact that schools of public health were being deleted altogether was of concern. Dr. Bishop stated that since Departments of Preventive and Community Medicine in Schools of Public Health receive federal support through other legislation, she did not believe that this proposed modification would significantly impact those schools. The Board agreed that this should be confirmed before endorsing the ATPM effort. Another possible problem which was discussed was whether the proposed language would inhibit the establishment of joint programs between Departments of Community/Preventive Medicine and Departments of Family Practice, Pediatrics, or Internal Medicine. It was suggested that staff seek clarification from ATPM on these two important points and that AAMC support of this proposal be tabled until further information is obtained for the Board's review.

V. The CAS Administrative Board adjourned at 1:00 p.m.

## CAS REPRESENTATIVE TO THE AAMC EXECUTIVE COUNCIL

As evidenced in the chart shown below, the term of Dr. Daniel Freedman as CAS Representative to the Executive Council expires this year. Therefore, it is necessary for the CAS Administrative Board to recommend to the Executive Council a successor for Dr. Freedman.

| | 1978-1979 | 1979-1980 |
|---|---|---|
| CAS Chairman | Oliver (80)* | Clemente (81) |
| CAS Chairman-Elect | Clemente (81) | (Chairman-Elect)(82) |
| CAS Past Chairman | Berne (79) | Oliver (80) |
| CAS Representative | Freedman (79) | _____ (83) |

*Tenure Expiration Date

## CAS NOMINATIONS FOR DISTINGUISHED SERVICE MEMBERSHIP

In 1973 the category of Distinguished Service Members was established. A proposal to modify the category of Senior membership to create Distinguished Service Membership in the AAMC was discussed. The Council of Academic Societies had disapproved it. The purpose of the proposal, which incorporates a Bylaws change, was to provide a mechanism for individuals once active in the AAMC to continue their active affiliation with one of the Councils after they no longer represent their institution or society on that Council. The Distinguished Service Members would be provided one vote on the Executive Council; no votes on any other Council or in the Assembly would be provided.

Considerable discussion focused on the propriety of this mechanism and the desirability of its objectives. Final action would have to be by the Assembly in November.

ACTION: *On motion, seconded and carried, the Executive Council approved with minor modifications the proposed Bylaws' change and guidelines to establish the category of Distinguished Service Membership in the AAMC. The guidelines are:*

1. *Senior members shall henceforth be called Distinguished Service Members.*

2. *Distinguished Service Members shall be elected by the Assembly on recommendation of the Executive Council and one of the constituent Councils.*

3. *The principal criterion for selection of Distinguished Service Members shall be active and meritorious participation in AAMC affairs while a member of one of the AAMC Councils. Additional criteria may be established by the Executive Council or constituent Council responsible for nominating Distinguished Service Members.*

4. *Each Distinguished Service Member shall have honorary membership status on the Council which recommended his/her election, i.e., he/she would be invited to all meetings and would have the privileges of the floor without vote.*

5. *Distinguished Service Members shall meet as a group once a year at the Annual Meeting and elect a Chairman and/or Chairman-Elect. (revised Bylaws attached to Archive minutes.)*

6. *Distinguished Service members shall be eligible for Emeritus Membership at age 65; Emeritus Membership would be mandatory at age 70.*

7. *AAMC Bylaws shall be modified to incorporate these changes and to provide Distinguished Service Members with voting representation on the Executive Council through an additional member of that Council.**

In 1974 the CAS nominated all previous Administrative Board members as Distinguished Service members, except for Dan Tosteson who was the AAMC Chairman that year. CAS has nominated no one since. Listed below are the past members of the Administrative Board.

CAS Administrative Board Members and Terms of Office

| | | |
|---|---|---|
| Thomas Kinney #+ | Duke | 1967-71 |
| Jonathan Rhoads *+ | U. of Pennsylvania | 1967-72 |
| Daniel Tosteson + | Duke | 1967-70 |
| Eben Alexander | Bowman Gray | 1967 |
| Harry Feldman * | SUNY Upstate | 1967-70 |
| Sam Clark, Jr. *+ | U. of Massachusetts | 1967-72 |
| Patrick Fitzgerald * | Cornell | 1967-71 |
| John Nurnberger # | Indiana | 1967-69 |
| Ralph Wedgwood * | U. of Washington | 1967-69 |
| James Warren * | Ohio State | 1968-71 |
| Charles Gregory # | Texas - Dallas | 1969-73 |
| William Weil * | Michigan State | 1969-73 |
| William Longmire | UCLA | 1970 |
| Louis Welt | North Carolina | 1970-72 |
| Robert Forster * | U. of Pennsylvania | 1971-73 |
| Ludwig Eichna * | SUNY Downstate | 1971-73 |
| Ernst Knobil | U. of Pennsylvania | 1970-74 |
| Ronald Estabrook + | Texas - Dallas | 1971-75 |
| Robert Petersdorf + | U. of Washington | 1971-76 |
| Robert Blizzard | U. of Virginia | 1972-74 |
| David Challoner | Indiana | 1972-75 |

| | | |
|---|---|---|
| Rolla Hill + | SUNY Upstate | 1972-77 |
| Jack Cole + | Yale | 1973-76 |
| Carmine Clemente | UCLA | 1973-81 |
| Leslie Webster | Case Western Reserve | 1973-77 |
| A. Jay Bollet + | SUNY Downstate | 1973-78 |
| D. Kay Clawson | U. of Washington | 1973-75 |
| F. Marian Bishop | Alabama | 1974-80 |
| Thomas K. Oliver | Pittsburgh | 1974-80 |
| Robert M. Berne + | U. of Virginia | 1974-79 |
| Philip R. Dodge | Washington University | 1975-78 |
| Daniel X. Freedman | Chicago - Pritzker | 1975-79 |
| Donald W. King | Columbia | 1975-76 |
| Roy C. Swan | Cornell | 1976-77 |
| Eugene Braunwald | Harvard | 1976-77 |
| Samuel O. Thier | Yale | 1976-79 |
| G. W. N. Eggers | U. of Missouri | 1976-79 |
| Frank E. Young | U. of Rochester | 1977-79 |
| David M. Brown | U. of Minnesota | 1977-81 |
| James B. Preston | SUNY Upstate | 1977-80 |
| Frank C. Wilson | U. of North Carolina | 1977-79 |
| T. R. Johns | U. of Virginia | 1978-81 |
| Virginia Weldon | Washington University | 1978-81 |

POSSIBLE ACTIONS:

1. Continue the moratorium on CAS nominations.
2. Nominate all past members of the Board who are not Distinguished Service Members and are not currently representatives to the Association from their societies.
3. Nominate only past chairmen who are no longer CAS representatives.
4. Nominate past CAS delegates to the Executive Council who are not CAS representatives
5. Nominate individuals selectively on the basis of merit and service, whether they have or have not served on the Board as long as they are no longer representatives.

* Distinguished Service Members

\+ Past Chairman

\# Deceased

## CLINICAL RESEARCH MANPOWER POOL

For several years there have been a variety of signs which suggest that the number of physicians preparing for and entering clinical research and academic medical careers is decreasing. The evidence that this is so is now incontrovertible. Dr. James Wyngaarden, President of the Association of American Physicians, reported May 6, 1979 that the latest NIH figures show a very sharp decline in the numbers of MDs and MD-PhDs supported on NIH postdoctoral research traineeships and a steady but less striking decline in direct research fellowship awards to these same groups. Approximate figures for recent years are as follows:

Approximate Number of Awards by NIH to MDs and MD-PhDs

| Year | Traineeship Positions | Direct Fellowships | Total |
|---|---|---|---|
| 1973 | 3600 | 350 | 3950 |
| 1974 | 3500 | 600 | 4100 |
| 1975 | 2750 | 450 | 3200 |
| 1976 | 1840 | 360 | 2200 |
| 1977 | 1400 | 400 | 1800 |

Dr. Wyngaarden suggested, as have others, a number of reasons for this alarming trend:

- changing student attitudes toward research careers
- changing public attitudes toward primary care
- changes in medical school curricula and student research opportunity
- unfavorable financial incentives for research as opposed to academic careers
- changed requirements of clinical specialty boards
- payback provisions for research fellowship support
- an unfavorable research grant climate

In the Executive Council agenda, AAMC staff give a progress report on their assessment of current student and faculty attitudes and opportunities for student research activities at U.S. medical schools. (An appendix to that Progress Report also provides more data about the trends in clinical research manpower supply. Your attention is invited to this Report.)

AAMC staff have also just concluded a study of the pool of qualified candidates for the medical scientist training programs supported by the NIH at 23 U.S. medical schools. These provide support for students in six-year combined MD-PhD programs. About 100 of the best young students enter the program each year. With the declining number of post-doctoral clinical research fellows the question has been asked: Is the number of applicants sufficiently high to allow

expansion of this program. We now have answers to this question which suggest that the program could be immediately doubled without seriously compromising the quality of the program.

Other suggestions for improving the clinical research picture have emerged from these and other studies. These suggestions will be discussed and plans formulated for appropriate AAMC action.

## AAMC CLINICAL EVALUATION PROJECT

Over 450 departments responded to a survey of the evaluation practices of clinical faculty involved in assessing the performance of clerks rotating through their core clerkships. Information was also obtained on the evaluation of residents.

Dr. Tonesk, who directs this project at AAMC, will be present at the Board Meeting to provide a brief progress report: the data collected, method of analysis, issues addressed, and possible implications. A report of the findings and conclusions will be available in the Fall and will be discussed at a special session at the AAMC Annual Meeting.

## CAS ANNUAL MEETING PLANS

Based on the discussion at the March Administrative Board Meeting, arrangements have been made for the following CAS functions:

| | | |
|---|---|---|
| Sunday, November 4 | 2:00-3:00 p.m. | CAS Plenary Session |
| | 3:00-5:00 p.m. | Small Group Discussions (5) |
| | 6:00-8:00 p.m. | Cocktails and Dinner (It is planned to hold this at a nearby restaurant rather than at the hotel.) |
| Monday, November 5 | 1:30-6:00 p.m. | CAS Business Meeting followed by speaker |

The Board should decide upon five topics for the discussion sessions. Topics which have been recommended include competency testing; the decline in clinical researchers; problems in clinical research; problems in basic research; federal support of medical education; specialty distribution; and accreditation. Also, the Board should recommend potential speakers for the conclusion of the CAS Business Meeting.

## ATPM LEGISLATIVE PROPOSAL

At the March Meeting, the CAS Board discussed the Association of Teachers of Preventive Medicine's efforts to modify the health manpower law when it comes up for renewal. The ATPM provided AAMC with a copy of its proposed modifications (p. 18) and requested that it be reviewed to determine whether AAMC found this effort to be acceptable and supportable. In March, the CAS Board raised specific concerns about the proposal and asked for further information on two specific points: 1) whether Schools of Public Health would be eligible for federal funding through other legislation since they would not be included as eligible for grants under the health manpower law if the ATPM modifications are adopted; 2) whether the ATPM proposal would serve as a disincentive or hindrance to the formation of joint or cooperative programs between Departments of Preventive or Community Medicine and other departments such as family practice, internal medicine, or pediatrics. AAMC staff contacted Dr. David Rabin, ATPM President-Elect, for a response to these concerns. Dr. Rabin's response will be a hand-out at the Board Meeting.

PREVENTIVE AND COMMUNITY MEDICINE

SPECIAL PROJECTS IN PREVENTIVE OR COMMUNITY MEDICINE

Section 1 (a) The Secretary may make grants to schools of medicine, dentistry or osteopathy for the costs of projects -

(1) to establish, maintain and improve academic administrative units in preventive or community medicine;

(2) to improve pre-doctoral and post-doctoral instruction in preventive or community medicine;

(3) to develop innovative educational programs which integrate the teaching of clinical preventive or community medicine within clinical programs for other medical disciplines;

(4) to plan, develop or operate post graduate programs in preventive or community medicine.

(b) to be eligible for grants under subsections (1) through (4) an applicant school must include an established academic administrative unit in preventive or community medicine.

PREVENTIVE AND COMMUNITY MEDICINE TRAINING

Section 2. The Secretary may make grants to any school of medicine, dentistry or osteopathy, or to or with any public or private

non-profit entity to meet the costs of -

(a) planning, development and operation of, or participation in, an approved residency training program in the field of preventive or community medicine;

(b) planning, development and operation of special programs to train teachers and researchers in the field of preventive or community medicine;

(c) financial assistance in the form of traineeships and fellowships or by other means for participants in such programs.

GRADUATE DEGREE PROGRAMS IN PREVENTIVE OR COMMUNITY MEDICINE

Section 3. The Secretary may make grants to schools of medicine -

(a) to develop graduate degree programs and expand accredited graduate degree programs in -

(1) community health/preventive medicine;

(2) community health/preventive medicine, with areas of emphasis in -

(a) biostatistics or epidemiology,

(b) health systems organization,

(c) health systems planning or policy analysis,

(d) environmental or occupational health,

(e) clinical dietetics or nutrition, or

(f) health promotion/health education

(b) for traineeships for students enrolled in such programs.

STUDIES AND STATISTICAL REPORT ON COMMUNITY HEALTH/PREVENTIVE MEDICINE PERSONNEL

Section 4 (a) The Secretary shall conduct and complete, not later than two years after the date of enactment of this Act, studies -

(1) to identify the various types of training programs currently offered for community health/preventive medicine personnel, including preventive medicine specialists;

(2) to determine the cost of educating and training such personnel;

(3) to identify and categorize the roles and functions of such personnel and the various training experiences which are relevant to such roles and functions; and

(4) to identify areas (both functional and geographic) in which there is a shortage of such personnel and the training programs which should be assisted to meet those shortages.

(b) In addition, the Secretary shall, in coordination with the National Center for Health Statistics (established under Section 306 of the Public Health Service Act), develop, publish and disseminate on a nationwide basis a report containing statistics and other information respecting community health/preventive medicine personnel, including preventive medicine specialists, which includes -

(1) detailed descriptions of the various types of such personnel and the activities in which such personnel are engaged;

(2) the current and anticipated needs for the various types of such health personnel, and

(3) the number, employment, geographic locations, surpluses and shortages of, as well as salary structures for, such personnel.