

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 18-19, 1983 ² [1984]

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MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 21-22, 1983
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

Frank C. Wilson, Chairman
Presiding
David M. Brown
Bernadine H. Bulkley
David H. Cohen
William F. Ganong
Lowell M. Greenbaum
Robert L. Hill
Joseph E. Johnson
Frank G. Moody

ABSENT: Douglas E. Kelly
John B. Lynch
Virginia V. Weldon

Staff

David Baime
John A.D. Cooper*
James Erdmann
Carolyn Henrich
Thomas Kennedy*
Joseph Keyes*
Lynn Morrison
Ann Scanley
John Sherman*
Elizabeth Short
August Swanson
Lucy Theilheimer
Xenia Tonesk
Kat Turner*

GUESTS: James D. Ebert
Thomas K. Oliver
Michael A. Stoto

The CAS Administrative Board convened on September 21 at 5:00 p.m. to prepare for a joint meeting with the Council of Deans (COD) Administrative Board beginning at 6:00 p.m. The purpose of the joint session was to discuss the National Academy of Sciences/Institute of Medicine study of the NIH organizational structure currently underway. Dr. James D. Ebert, chairman of the IOM Committee on the Study of the Organizational Structure of the NIH and Dr. Michael A. Stoto, study director, were invited to participate in an open, informal discussion with the two Boards (see page 3).

At this meeting, the CAS Administrative Board welcomed Dr. Elizabeth Short as the new director of the AAMC's Division on Biomedical Research and Faculty Development. The meeting adjourned at 7:00 p.m. for a social hour followed by dinner at 7:45. At 9:00 p.m., the CAS Board was invited to a special preview showing of a videotape of the keynote address from an AAMC seminar, "The Medicare Prospective Payment System: Implications for Medical Schools and Faculties."

The CAS Administrative Board reconvened at 9:00 a.m. on September 22 for a business meeting. The Board joined the other Administrative Boards for a joint luncheon meeting at 12:30 p.m.

* present for part of meeting

I. APPROVAL OF MINUTES

The minutes of the June 29-30, 1983 CAS Administrative Board meeting were approved as submitted.

II. ACTION ITEMS - CAS Board

A. Membership Applications

Members of the CAS Board had been asked to review the applications of the American Association of Directors of Psychiatric Residency Training and the American Society for Cell Biology for membership in the CAS. Both societies' applications were recommended for approval.

ACTION: The CAS Administrative Board voted to approve the applications for CAS membership.

B. Institute of Medicine Study of the NIH Organizational Structure

The National Academy of Sciences, Institute of Medicine has begun a study of the organizational structure of the National Institutes of Health. Former HHS Secretary Richard Schweiker initiated the study in response to increasing public and political pressure to alter or expand the current NIH structure. The purpose of the study is: 1) to develop criteria to be used when assessing the need to make any substantial organizational changes, and 2) to consider possible alternatives to the current NIH structure. The study's recommendations will have major impact on the extent to which the public and the Congress will determine the program directions of the NIH.

An IOM committee has been appointed to conduct the study. In addition, separate panels will be formed to consider historical issues relating to the organizational structure of the NIH, the current structure, and possible alternative structures. To aid the committee and panels, public hearings will be held on September 26-27 to allow the opportunity for organizations and individuals to offer their views. Fifteen organizations, including the AAMC, have been invited to testify. (A number of CAS member societies were also invited to submit comments and all CAS presidents have been notified of the hearings and were encouraged to submit comments.) The AAMC's draft comments were distributed to the Board for review and comment. A summary of the recommendations appears below:

- That the current general structure of the NIH be retained
- That the present system of program selection and project funding based on scientific promise and quality be maintained
- That a powerful case be made to convince the Congress to refrain from detailed statutory prescription regarding the NIH, to rely instead on general authorities, and to focus on "systems" problems through oversight
- That some more explicit limitation be established on the number of operating units within the NIH, and that the NIH be required to reaffirm or revise its organizational structure every 10 years (after a thorough study including consideration of the recommendations of all relevant voluntary health organizations)

- That the office of the Director, NIH, be strengthened to assure that problems of the type mentioned are adjudicated or otherwise addressed (To this end, the Director should have authority to transfer limited amounts of funds or limited segments of programs among operating units.)
- That the NIH establish a formal, highly visible forum in which advocates of programs could present their views and learn of the extent to which research relevant to their concerns/interests is under way. (A careful record of such meetings, together with analyses by NIH of the state-of-the-art in that subject area, should be incorporated into the budget development process and made available to DHHS, the OMB and the Congress for perusal.)

On the evening of September 21, Dr. James D. Ebert, chairman of the IOM Committee on the Study of the Organizational Structure of the NIH, and Dr. Michael A. Stoto, study director, had joined the CAS and COD Boards for an open discussion of the conduct and scope of the study. Dr. Ebert reviewed the purpose of the study and the structure/membership of the Committee and panels. The fifteen organizations invited to testify were identified. There was discussion of the criteria used to select these organizations as the large majority appeared to be disease-specific and narrow in focus. Dr. Ebert reported that most comments received thus far focussed on the peer review system. He also discussed the scope of the study in terms of the issues the Committee would address and noted that the issues of separate institutes, efforts to expand the NIH mission, and criteria for organizational change will be studied in-depth. The two Boards expressed concern with respect to the Committee's view that the peer review system and external factors which impact on the NIH were not within the purview of its charge. The question as to whether the Committee will consider comments with respect to the extramural and intramural programs at the NIH has not yet been determined. The Boards also expressed concern that the time frame for the study appeared extremely tight given the potential impact of the recommendations on the future of the NIH and biomedical research. In conclusion, Dr. Ebert expressed the opinion that the time is limited but workable and that overall, some 450 organizations will have had an opportunity to provide input.

ACTION: The CAS Administrative Board voted to endorse the AAMC recommendations to the IOM with minor editorial modifications. The Board also urged that the AAMC consider a stronger statement with respect to the proliferation of institutes.

III. ACTION ITEMS - Executive Council

A. Blacks and the Health Professions in the 80s: A National Crisis and a Time for Action

Dr. John A.D. Cooper, AAMC president, briefly discussed the recommendations of the report, "Blacks and Health Professions In the 80s: A

National Crisis and a Time for Action," prepared by the Association of Minority Health Profession Schools (AMHPS). AMHPS membership includes Meharry Medical College and the Morehouse School of Medicine. Dr. Cooper reported that many of the findings and recommendations are consistent with those of the AAMC's 1978 Task Force on Minority Student Opportunities in Medicine, although there are some inconsistencies in the data. The report concludes that enrollment at Meharry be restored to 100 students per class and that Morehouse be expanded to 64 students per class.

The CAS Board was asked to consider whether or not AAMC endorsement of the report is appropriate.

- ACTION:** The CAS Administrative Board commended the AMHPS for its timely report and welcomed the additional evidence of the need to increase opportunities for underrepresented minorities at all levels of medical education. The Board reaffirmed its support of this worthy goal and recommended that:
- The Liaison Committee on Medical Education explore increasing class size at Meharry and Morehouse, and
 - The Federal government make supportive grants to these schools

B. Issues Related to Appointment to PGY-2

Dr. Cooper provided background on several problems associated with the selection of students into a number of specialty programs--primarily in the context of "career" specialty selection where this is not contiguous with PGY-1 selection. Six specialties currently follow a timetable which differs from that of the NRMP: Anesthesiology, Dermatology, Neurology, Ophthalmology, Psychiatry, and Radiology. It is felt by a number of deans that earlier and different schedules are burdensome to students as they require earlier decisions, two or more application and interview cycles, and, by advancing the time of the application and interview, preparation of a dean's letter with less than the optimal amount of information.

Dr. Cooper pointed out that Dr. Jack Graettinger has made significant improvements in the NRMP but that problems still exist. The program should be able to accommodate the requirements of program directors. The AAMC could assume the role of mediator between the NRMP and the specialties in question.

The CAS Administrative Board was asked to consider options which might lead to a consensus among concerned parties.

- ACTION:** The CAS Board agreed to recommend that:
- The AAMC's Executive Committee and selected CAS representatives meet with representatives of the specialties currently operating outside NRMP
 - CAS representatives from relevant specialty societies meet with groups of program directors
 - Changes regarding the NRMP result book be drafted for distribution to program directors prior to such meetings

C. Principles for the Support of Biomedical Research

Dr. John Sherman, AAMC vice president, provided background on the development of the draft document, "Principles for the Support of Biomedical Research," and the accompanying strategy document. Stimulated by the controversy surrounding pending NIH reauthorization legislation, at its April meeting, the AAMC Executive Council determined that a basic set of principles with respect to support of the biomedical research enterprise is needed to convey the concerns of the research community. Such a document would transcend political considerations. A first draft was reviewed by the Administrative Board and Executive Council in June and a revised draft was presented to an ad hoc committee comprised of representatives from each of the Councils in August. The existing draft incorporates the recommendations and suggestions made during those meetings. Dr. Sherman noted that the document (in draft form) has been included in the AAMC's preliminary comments to the Institute of Medicine regarding the NIH organizational structure. He added that a recommendation to assure that special interest groups have input on matters relevant to the NIH will be included in the final principles document.

The CAS Administrative Board was asked to adopt the "Principles for the Support of Biomedical Research" as official AAMC policy and endorse the strategy for furthering the objectives stated in the document.

The Board discussed the most effective mechanisms for furthering the identified goals. It was pointed out that the document will serve as a focal point for the CAS annual meeting.

ACTION: The CAS Administrative Board endorsed the document and recommended that:

- The document be put into the form of a white paper and distributed to the academic community in an effort to gain the support of colleagues
- The CAS seek support for the principles document and assistance in promoting the concepts from member societies (Such efforts should be targeted at scientific groups, voluntary health organizations, the public, and the Congress.)
- The principles document be sent to voluntary health organizations along with a cover letter urging them to focus their efforts on the appropriations rather than authorization process

The Board also recommended that the CAS be well represented on any ad hoc committee formed to develop further and implement a strategy for the promotion of the principles document.

D. Recent Action on Medical Education Financing By the Advisory Council on Social Security

Dr. Cooper reported that in August of this year, the Advisory Council on Social Security adopted a resolution calling for a three year study of medical education financing as the first step in an "...orderly withdrawal of Medicare funds from training support." In an effort to get the Council to reconsider its resolution, the AAMC proposed a study of alternative means of financing medical education. The findings could be used to debate the reasonableness of terminating support for medical education. The CAS Administrative Board was asked to

consider this proposal as an appropriate response to the Advisory Council's action.

ACTION: The CAS Administrative voted to endorse the AAMC's proposal to recommend to the Advisory Council a study of alternative means of financing medical education and a subsequent determination of the reasonableness of terminating support for medical education.

IV. DISCUSSION ITEMS - CAS Board

A. CAS Fall Meeting Plans

Lucy Theilheimer of the AAMC staff reviewed the plans for the CAS fall meeting as discussed at the June Board meeting. The November 6 session of the meeting will focus on the theme, "Research Support: A Consensus is Needed." The following presentations will be made:

- Research Funding Priorities of the NIH
William F. Raub, Ph.D., Associate Director for Extramural Research, NIH
- Statement of Basic Principles of the Nation's Medical Research Program
John F. Sherman, Ph.D., Vice President, AAMC
- Congressional "Micromanagement" of the NIH
John Walsh, Reporter for News and Comment, SCIENCE
- The Science of Politics and the Politics of Science
Leonard Heller, Ph.D. (former Robert Wood Johnson Foundation Policy Fellow) Vice Chancellor for Academic Affairs, University of Kentucky Medical Center
- Can Biomedical Research Survive Attacks of Confused Lucidity?
Sherman M. Mellinkoff, M.D., Dean, UCLA School of Medicine

A CAS Reception will be held following this program.

The CAS Business Meeting had been scheduled for the afternoon of November 7. The agenda will include election of the administrative board and new members as well as the usual legislative update. In addition, Dr. Hill, as chairman of the National Research Council's Committee on a Study of National Needs for Biomedical and Behavioral Research Personnel, will make a brief presentation regarding the Committee's findings and recommendations. Updates will be provided on the General Professional Education of the Physician Project, the AAMC Clinical Evaluation Project, the Institute of Medicine study of the NIH organizational structure. In addition, the implications for faculty of the Medicare Prospective Payment system will be addressed.

The CAS Board felt the following issues should be added to the agenda for the November 7 Business Meeting:

- Issues related to appointment to PGY-2
- Indirect costs
- Support and promotion of the "Principles for the Support of Biomedical Research"

B. CAS 1984 Interim Meeting

Lynn Morrison of the AAMC staff discussed a number of options regarding the Interim Meeting. She noted that in recent years it has become evident that the officers of many CAS member societies are not involved in or even aware of AAMC activities. In addition, it seems clear that the officers of these societies have not established efficient mechanisms for contacting their members in a timely manner regarding important issues. If the CAS Board in fact decides to plan an Interim Meeting in 1984, it might consider the possibility of a meeting--held in the Spring--for CAS presidents, public affairs representatives, executive directors and CAS representatives. One purpose of the meeting would be to discuss ways of improving: 1) the liaison between the society officers and the AAMC, and 2) methods of communication between the officers and members of societies. A specific issue such as FY 1985 NIH appropriations or NIH authorization legislation could serve as the vehicle for discussion of these concerns.

The Board discussed the feasibility of getting society presidents to attend such a meeting. They agreed that the meeting announcement should not actually define communication concerns as the purpose of the meeting. The Board did agree that an interim meeting along these lines would be useful and tentatively scheduled it for April 10-11, 1984 in conjunction with the Administrative Board meeting already planned for April 11-12.

C. Indirect Costs

Dr. Cooper discussed the controversy surrounding indirect costs as well as the lack of communication between university administrators and faculty with respect to this issue. In fact, he noted that administrators appear to be unaware of the dissension that exists among investigators regarding the legitimacy of such costs. Dr. Cooper went on to report on a meeting attended by representatives of university administration, and the scientific community. The purpose of the meeting was to begin exploring how to effectively address the questions surrounding the subject of indirect costs. As a result of the meeting, a letter was sent to all university presidents (signed by all those who participated in the meeting) that outlined four major points on which the group had agreed:

- A healthy biomedical research venture supported by full funding is a vital national objective; (In that context, the group is committed to supporting the efforts of the Coalition for Biomedical Research Funding, a group of some 135 organizations that has coalesced in the last two years to advocate adequate increases in the NIH budget.)
- There is a need to resolve the problem of indirect costs because they pose a singular threat of discord within the academic community and frequently lead to mixed messages to the public and the Congress; (It was tentatively agreed that the President's Science Advisor should be asked to see that a study of the issue be undertaken to address the reasons for the increases in indirect costs, ways to control them and, if possible, reduce them.)

- University presidents should urge their colleagues to enhance their efforts to present their faculties with clear explanations of what indirect costs are and how their institutions handle them. (In addition, it was agreed that faculty should be meaningfully involved in the development of institutional policies regarding indirect costs.

The CAS Board discussed possible ways to encourage faculty to become more actively involved in discussions regarding indirect costs at their institutions.

D. Nondiscrimination on the Basis of Handicap

Lucy Theilheimer reported on recent regulatory and legislative activity on the subject of medical treatment for handicapped infants.

In response to the proposed regulations, the AAMC submitted an alternative proposal calling for the establishment of ethics review boards within each institution or community to address such cases in which a decision to forego life sustaining treatment must be made. This is consistent with the recommendation of the President's Commission on Ethical Behavior in Medicine and Biomedical and Behavioral Research.

V. DISCUSSION ITEM - Executive Council

A. Legislative Update

Dr. Thomas Kennedy of the AAMC staff provided a brief update on current legislative activity. He reported on the status of the FY 1984 appropriations bills, NIH reauthorization legislation, proposals regarding the use of animals in research, and pending hazardous waste legislation dealing primarily with the degree to which the small quantity generator exemption should be narrowed.

It was noted that NIH reauthorizing legislation may fail to pass both chambers. The CAS Board discussed the impact this might have on the support of research trainees. (Training and medical library assistance are not covered by the open-ended authority of Section 301 of the Public Health Service Act as are the other NIH components addressed by the legislation.) It was expected that training funds would be provided under a continuing resolution.

APPOINTMENT OF 1984 CAS NOMINATING COMMITTEE

Section V, #1 of the CAS Bylaws reads as follows:

"The Nominating Committee shall be comprised of seven members. The Chairman of the Administrative Board shall be the Chairman of the Nominating Committee and shall vote in the case of a tie. Six individuals (three basic science and three clinical science) shall be appointed by the CAS Administrative Board from among representatives of the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board. The Nominating Committee shall report to the Council at its Annual Meeting a slate of nominees for Administrative Board vacancies. Additional nominations for these positions may be made by any representative to the Council present at the meeting. The Committee will also recommend to the AAMC Nominating Committee candidates for Chairman-Elect of the Association of American Medical Colleges."

On the following pages is a list of all CAS Representatives from which the Board must choose three basic scientists and three clinical scientists to serve on the CAS Nominating Committee. Several alternates should also be selected. The Committee will meet by conference call some time in May or early June to develop a slate of nominees to fill one basic and two clinical science positions. The Committee will also nominate a basic scientist as Chairman-Elect of CAS and an individual from the Council of Academic Societies to serve as Chairman-Elect of the AAMC.

The 1980-1983 CAS Nominating Committees are listed below.

1980

Carmine D. Clemente, Ph.D., Chairman
George N. Aagaard, M.D.
Milton T. Edgerton, M.D.
Daniel X. Freedman, M.D.
Mary Ellen Jones, Ph.D.
Thomas K. Oliver, M.D.
Solomon Snyder, M.D.

1981

Daniel X. Freedman, M.D., Chairman
Robert M. Berne, M.D.
F. Marian Bishop, Ph.D.
David M. Brown, M.D.
David H. Solomon, M.D.
Warren Stamp, M.D.
Frank C. Wilson, M.D.

1982

David M. Brown, M.D., Chairman
Joseph R. Bianchine, Ph.D.
T. R. Johns, M.D.
Franklyn G. Knox, M.D., Ph.D.
John T. Sessions, Jr., M.D.
Frank C. Wilson, M.D.
Robert D. Yates, Ph.D.

1983

Frank C. Wilson, M.D., Chairman
Arthur J. Donovan, M.D.
Thomas W. Langfitt, M.D.
Robert M. Blizzard, M.D.
Robert L. Hill, M.D.
Howard E. Morgan, M.D.
Leonard Jarett, M.D.

CAS REPRESENTATIVES AND PUBLIC AFFAIRS REPRESENTATIVES

BASIC SCIENCES

ANATOMY

American Association of Anatomists
Dr. John E. Pauly
Dr. Sanford L. Palay
Dr. George D. Pappas (PAR)
Association of Anatomy Chairmen
Dr. Leonard L. Ross
Dr. Douglas E. Kelly (PAR & Rep)

BEHAVIORAL SCIENCE

Association for the Behavioral Sci. & Med. Education
Shirley Nichols Fahey, Ph.D.
Evan G. Pattishall, Jr., M.D. (PAR & Rep)

BIOCHEMISTRY

American Society of Biological Chemists, Inc.
Dr. Robert L. Hill
Dr. Robert M. Bock (PAR)
Assoc. of Med. School Depts. of Biochemistry
Dr. Lowell P. Hager
Dr. Robert L. Hill
Dr. Eugene Davidson (PAR)

GENETICS

American Society of Human Genetics
David Rimoin, M.D.
John W. Littlefield, M.D.
Robert L. Summitt, M.D. (PAR)

MICROBIOLOGY

Assoc. of Med. School Microbiology Chairmen
Harold S. Ginsberg, M.D.
Kenneth I. Berns, M.D. (PAR & Rep)

NEUROSCIENCE

Society for Neuroscience
Dr. Joe Dan Coulter
Dr. David H. Cohen (PAR & Rep)

PHARMACOLOGY

American College of Neuropsychopharmacology
Oakley Ray, Ph.D.
Arnold Friedhoff, M.D. (PAR & Rep)
American Soc. for Clinical Pharm. & Therapeutics
Arthur Hull Hayes, Jr., M.D.
George N. Aagaard, M.D. (PAR & Rep)
Amer. Soc. for Pharm. & Experimental Therapeutics
Dr. Lewis Aronow
Dr. William L. West (PAR & Rep)
Assoc. for Medical School Pharmacology
Joseph Bianchine, Ph.D.
Lowell Greenbaum, Ph.D. (PAR & Rep)

PHYSIOLOGY

American Physiological Society
Franklyn G. Knox, M.D., Ph.D.
Jack L. Kostyo, Ph.D.
John T. Shepherd, M.D., D.Sc. (PAR)
Assoc. of Chairmen of Depts. of Physiology
Dr. William F. Ganong
Dr. Howard E. Morgan
Dr. Norman A. Alpert (PAR)

CLINICAL SCIENCES

ALLERGY

American Academy of Allergy
Paul Vanarsdel, M.D.
Thomas E. Van Metre, M.D. (PAR)

ANESTHESIOLOGY

Association of University Anesthetists
C. Philip Larson, Jr., M.D.
Nicholas M. Greene, M.D. (PAR & Rep)
Society of Academic Anesthesia Chairmen
Robert M. Epstein, M.D.
S. Craighead Alexander, M.D. (PAR & Rep)

CLINICAL RESEARCH

American Assoc. for the Study of Liver Diseases
E. Lee Forker, M.D.
Harold J. Fallon, M.D.
Michael Sorrell, M.D. (PAR)
American Federation for Clinical Research
Bernadine Bulkley, M.D.
Randall M. Zusman, M.D. (PAR & Rep)
American Society for Clinical Investigation
Suzanne Oparil, M.D.
William N. Kelly, M.D. (PAR & Rep)
Central Society for Clinical Research
Murray L. Levin, M.D. (PAR & Rep)
Plastic Surgery Research Council
Jane A. Petro, M.D.
Robert L. Ruberg, M.D.
Martin C. Robson, M.D. (PAR)
Society for Gynecologic Investigation
W. Ann Reynolds, Ph.D.
Ronald A. Chez, M.D.
Robert B. Jaffe, M.D. (PAR)
Society for Pediatric Research
Virginia V. Weldon, M.D.
Richard E. Hillman, M.D.
Lynn M. Taussig, M.D. (PAR)

DERMATOLOGY

Association of Professors of Dermatology, Inc.
Phillip C. Anderson, M.D.
J. Graham Smith, Jr., M.D.
Peyton E. Weary, M.D. (PAR)

EMERGENCY MEDICINE AND CRITICAL CARE

Society of Critical Care Medicine
Solomon G. Hershey, M.D. (PAR & Rep)
Society of Teachers of Emergency Medicine
Richard M. Nowak, M.D.
John Lumpkin, M.D.
Daniel T. Schelble, M.D. (PAR)

ENDOCRINOLOGY

Endocrine Society
Jo Anne Brasel, M.D.
Virginia V. Weldon, M.D.
Claude J. Migeon, M.D. (PAR)

FAMILY MEDICINE

Association of Departments of Family Medicine
Thomas Leaman, M.D.
Thornton Bryan, M.D.
Fitzhugh Mayo, M.D. (PAR)
Society of Teachers of Family Medicine
B. Lewis Barnett, Jr., M.D.
Jack M. Colwill, M.D. (PAR)

GENERAL SURGERY

American Association for the Surgery of Trauma
William R. Drucker, M.D.
Donald S. Gann, M.D. (PAR & Rep)
American Surgical Association
Arthur J. Donovan, M.D.
Jerome J. DeCosse, M.D., Ph.D. (PAR & Rep)
Association for Academic Surgery
John Clark, M.D.
Caliann G. Lum, M.D.
Charles M. Balch, M.D. (PAR)
Soc. for Surgery of the Alimentary Tract, Inc.
John R. Brooks, M.D.
John Cameron, M.D.
Bernard M. Jaffe, M.D. (PAR)
Society of Surgical Chairmen
Frank G. Moody, M.D.
David B. Skinner, M.D.
Norman M. Rich, M.D. (PAR)
Society of University Surgeons
John W. Harmon, M.D.
Morris D. Kerstein, M.D.
Alden Harken, M.D. (PAR)

INTERNAL MEDICINE

American College of Physicians

Marvin Turck, M.D., FACP

Thomas W. Burns, M.D., FACP

John R. Ball, M.D. (PAR)

Association of American Physicians

Leighton E. Cluff, M.D.

Alfred Jay Bollet, M.D.

Oscar D. Ratnoff, M.D. (PAR)

Association of Professors of Medicine

Jay H. Stein, M.D.

Joseph E. Johnson, III, M.D. (PAR & Rep)

Association of Program Directors in Internal Med.

Pervis Milnor, Jr., M.D.

Louis M. Sherwood, M.D. (PAR & Rep)

American Gastroenterological Association

Irwin H. Rosenberg, M.D.

Susan C. Stewart, M.D.

Clarence Legerton, M.D. (PAR)

American Society of Hematology

Ernst R. Jaffe, M.D.

Paul R. McCurdy, M.D. (PAR & Rep)

NEUROLOGY

American Academy of Neurology

Rosalie A. Burns, M.D.

Jerry Chutkow, M.D.

John F. Aita, M.D. (PAR)

American Neurological Association

Arthur K. Asbury, M.D.

Frank M. Yatsu, M.D. (PAR & Rep)

Association of University Professors of Neurology

Elliott L. Mancall, M.D.

Hartwell G. Thompson, M.D. (PAR & Rep)

Child Neurology Society

Raymond W. M. Chun, M.D.

Mary Anne Guggenheim, M.D.

Herbert Swick, M.D. (PAR)

NEUROSURGERY

American Association of Neurological Surgeons

Thomas W. Langfitt, M.D.

John Shillito, M.D. (PAR & Rep)

OBSTETRICS AND GYNECOLOGY

Amer. College of Obstetricians and Gynecologists

Warren H. Pearse, M.D.

Harry S. Jonas, M.D.

Ervin E. Nichols, M.D. (PAR)

Assoc. of Professors of Gynecology and Obstetrics

Joseph C. Scott, Jr., M.D.

Douglas R. Knab, M.D.

Allan B. Weingold, M.D. (PAR)

OPHTHALMOLOGY

American Academy of Ophthalmology

Robert D. Reinecke, M.D.

Melinda Hatton, (PAR)

Association of University Professors of Ophthalmology

Robert D. Reinecke, M.D.

Randall J. Olson, M.D. (PAR)

ORTHOPAEDICS

American Academy of Orthopaedic Surgeons

Charles V. Heck, M.D.

Frank C. Wilson, M.D.

John J. Gartland, M.D. (PAR)

Association of Orthopaedic Chairmen

Frank C. Wilson, M.D.

John P. Adams (PAR & Rep)

OTOLARYNGOLOGY

Assoc. of Academic Depts. of Otolaryngology

Warren Y. Adkins, M.D.

Robert I. Kohut, M.D. (PAR & Rep)

Society of University Otolaryngologists

Jerome Goldstein, M.D.

John M. Fredrickson, M.D. (PAR & Rep)

PEDIATRICS

American Pediatric Society

Virginia V. Weldon, M.D.

Audrey K. Brown, M.D. (PAR & Rep)

Assoc. of Med. School Pediatric Dept. Chairmen, Inc.

Thomas K. Oliver, M.D.

Robert M. Blizzard, M.D. (PAR)

PHYSICAL MEDICINE AND REHABILITATION

Amer. Acad. for Physical Medicine and Rehabilitation

Murray M. Freed, M.D.

B. Stanley Cohen, M.D.

Justus F. Lehmann, M.D. (PAR)

Association of Academic Physiatrists

William E. Stass, Jr., M.D.

Theodore M. Cole, M.D.

John Goldschmidt, M.D. (PAR)

PLASTIC SURGERY

American Association of Plastic Surgeons

Hal G. Bingham, M.D.

Charles E. Horton, M.D.

John Remensnyder, M.D. (PAR)

Plastic Surgery Educational Foundation

R. Barrett Noone, M.D. (PAR & Rep)

PSYCHIATRY

Amer. Assoc. of Chairmen of Depts. of Psychiatry

Daniel X. Freedman, M.D.

Jerry M. Wiener, M.D.

Paul J. Fink, M.D. (PAR)

Association for Academic Psychiatry

Larry Silver, M.D.

Thomas G. Webster, M.D. (PAR & Rep)

Assoc. of Directors of Med. Student Educ. in Psychia

Marshall Swartzberg, M.D.

George U. Balis, M.D.

Cornelis Heijn, Jr., M.D. (PAR)

RADIOLOGY

Association of University Radiologists

Paul J. Friedman, M.D.

A. Everette James, Jr., M.D. (PAR & Rep)

Soc. of Chairmen of Acad. Radiology Departments

Ralph Alfydi, M.D.

Larry P. Elliott, M.D.

A. Everette James, Jr., M.D. (PAR)

THORACIC SURGERY

American Association for Thoracic Surgery

Judson G. Randolph, M.D.

Clarence S. Weldon, M.D. (PAR & Rep)

Thoracic Surgery Directors Association

Benson R. Wilcox, M.D.

Hermes C. Grillo, M.D. (PAR & Rep)

UROLOGY

Society of University Urologists

William L. Parry, M.D.

Harry C. Miller, Jr., M.D.

Robert K. Rhamy, M.D. (PAR)

HEALTH AND HUMAN VALUES

Society for Health and Human Values

Joel Frader, M.D.

David C. Thomasma, Ph.D.

James A. Knight, M.D. (PAR)

PATHOLOGY AND CLINICAL LABORATORIES

Association of Pathology Chairmen, Inc.

Leonard Jarett, M.D.

Rolla B. Hill, M.D. (PAR & Rep)

Acad. of Clinical Lab. Physicians and Scientists

David M. Brown, M.D. (PAR & Rep)

PREVENTIVE MEDICINE

Association of Teachers of Preventive Medicine

David L. Rabin, M.D.

Dennis J. Barbour, M.D. (PAR)

CONSIDERATION OF RESIDENT INVOLVEMENT IN THE AAMC

In September 1983 the Executive Council referred to the Council of Academic Societies' administrative board a request by the Organization of Student Representatives administrative board that residents be incorporated into the AAMC constituency and provided an organizational role in the association. The issue of resident representation to the AAMC was discussed by the Council of Deans' administrative board in September. The board recognized that residents are involved in medical education, both as graduate students and as teachers of medical students. The board expressed the belief that this involvement is important, and their incorporation into the AAMC should be explored by the Council of Academic Societies.

The involvement of residents in the AAMC was last considered by the Executive Council in 1979. At that time an ad hoc committee recommended that there be periodic invitational conferences with residents on subjects related to their interests in medical education. The first conference, in the fall of 1979, was on the draft report of the association's Task Force on Graduate Medical Education. In the winter of 1981, there was a conference on evaluation in graduate medical education. The most recent conference was in November, 1983. It focused on the General Professional Education of the Physician project. For each conference 36 residents were selected from nominations submitted by medical school deans and the OSR administrative board. These conferences have been useful both for the residents who have attended and for the provision of their insights to the association. In the main, the residents that have been nominated have been individuals who have a strong interest in pursuing a career in academic medicine.

The AAMC is an association of academic institutions and academic organizations. Individuals involved in the association are selected by and represent either an academic institution or organization. The central issue about formal representation of residents in the governance structure of the AAMC is who would those involved represent, and how representative might they be? Residents have two educational relationships: the first is to their specialty program and the second is to the institution that sponsors that program. There are 24 types of specialty programs accredited by the Accreditation Council for Graduate Medical Education, and there are 4,573 total programs. Were residents selected by specialty, it seems unlikely that one or two representatives from each specialty could truly represent the concerns of residents from diverse programs in so many specialties. There are 415 institutional members of the Council of Teaching Hospitals. A resident representative from each of these would create a body of unwieldy size. Further, representation would in many cases be duplicative since many COTH institutions have integrated programs with other COTH members. For example, Veterans' Administration Hospitals have almost totally integrated programs.

Balanced representation presents problems. Were CAS societies to designate resident representatives, there would be duplications, depending upon the number of societies of the various specialties that are members of the CAS.

For example, there are 6 member societies included under general surgery and 6 under internal medicine, while there are only 2 member societies from pediatrics and 2 from obstetrics-gynecology. If residents were to be designated by clinical academic societies, it would appear that graduate students or postdoctoral students should be designated by the basic science societies. There are 15 basic science society members in CAS; 4 of these are pharmacology societies. Other disciplines are represented by 1 or at the most 2 societies. An institutional representative could be designated by each COTH member hospital, but there would be no assurance that the full spectrum of specialties would be represented by these designees, and the basic science societies would not likely be represented.

Cost is also a significant factor. For the institutions or organizations, sending a representative to 2 meetings a year would cost \$1,000 to \$1,200. Many of the small professorial CAS societies would find this a financial burden. For the association the cost would depend upon the organizational structure and program that is developed. Were the OSR structure and program to be duplicated for residents, the cost would approximate \$100,000 per year.

Since a balanced representation of residents by individuals with a significant interest in the broad spectrum of graduate medical education appears infeasible, alternative methods for resident and graduate student input into the association should be considered. One of these is to continue the periodic invitational conferences. Depending upon the subject, graduate and postdoctoral students in the basic science disciplines could be included. Resident and graduate students can also be appointed to AAMC committees and task forces. Both the Graduate Medical Education Task Force and the GPEP panel have had resident members. Another alternative would be to encourage the CAS societies that have a resident-member complement to either designate a resident as one of their 2 CAS representatives or to extend those societies the privilege of sending a resident to CAS meetings as a non-voting participant observer.

FUTURE DIRECTIONS FOR THE COUNCIL OF ACADEMIC SOCIETIES

At the annual Officers Retreat an examination of the membership, activities, and future challenges for the Council of Teaching Hospitals was reviewed. There was a consensus that a similar examination by the Council of Deans and the Council of Academic Societies is timely. The following is presented to assist the Administrative Board in its consideration of how a useful examination of the membership, activities, and future challenges for the Council of Academic Societies might be conducted.

Establishment and Early History

The 1965 report authored by Lowell Coggeshall entitled "Planning for Medical Progress Through Education" had a profound effect on the AAMC. One of the recommendations was that a Council of Faculty should be established. The report states, "This Council should provide for all participation of faculty representatives, selected for their broad interest in education for health and medical sciences. It should be concerned primarily with matters of curriculum, education content, and educational methods."

The concept of a Council of Academic Societies as the mechanism for faculty representation to the AAMC was developed by a Task Force chaired by Dr. Kenneth Crispell, Dean of the University of Virginia. In September 1966 the Task Force presented the following recommendations to the Executive Council. These were accepted and in October 1966 approved by the institutional membership.

"We recommend the formation of a Council of Academic Societies.

1. An Academic Society is defined as a society which has as a prerequisite for membership appointment to a medical school faculty or a society which in the opinion of the Executive Council of the Association of American Medical Colleges has as one of its major functions a commitment to the problems of medical education.
2. The societies to be represented on the Council of Academic Societies will be proposed by the Executive Council and determined by a vote of the institutional members.

3. To form the Council, each of the selected societies will be asked by the Executive Council of the AAMC to designate two members, one of whom shall be a department chairman and one a faculty member not holding a major administrative position.
4. The Council of Academic Societies will nominate four members to the Executive Council of the AAMC -- two from the basic sciences and two from the clinical sciences.
5. In those teaching disciplines in which such societies do not now exist, the teaching discipline may be given the same consideration as academic societies for membership in the Council of Academic Societies and be invited to nominate two members to the Council of Academic Societies. Subsequently, they may be encouraged to form such a society.
6. This Council of Academic Societies would be encouraged to function as an integral part of the regional organization of the AAMC."

The first organizational meeting of the Council of Academic Societies was held in January 1967. The summary of that meeting is included because it illustrates the range of concepts of what the role of the Council of Academic Societies might be in the AAMC, the academic community, and the national structure of medicine and the biomedical sciences.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATIONAL MEETING OF THE COUNCIL OF ACADEMIC SOCIETIES

January 10, 1967

Ramdada Inn-O'Hare, Chicago, Illinois

- PRESENT:** William N. Hubbard, Jr., Chairman
 Robert C. Berson
 Cheves McC. Smythe
- | | |
|-----------------------|----------------------|
| George Aagaard | Thomas D. Kinney |
| Eben Alexander, Jr. | A. Edward Maumenee |
| John A. Campbell | Jonathan Rhoads |
| Philip P. Cohen | Morris Frank Shaffer |
| Kenneth R. Crispell | Robert Slater |
| James B. Snow, Jr. | Daniel C. Tosteson |
| Donald Duncan | Raymond F. Waggoner |
| Harry A. Feldman | James V. Warren |
| Patrick J. Fitzgerald | Ralph Wedgwood |
| Robert E. Forster | Robert H. Williams |
| A. Donald Merritt | Russell T. Woodburne |

Dr. William N. Hubbard, Jr., as Chairman, opened the meeting at 10:00 a.m. January 10, 1967 with a charge to the group present that they use the first hours of the meeting to examine the organizational structure proposed in the memorandum submitted to them. The purpose of the meeting is to find a way to include faculty in an influential manner within the Association of American Medical Colleges so that as the AAMC continues in its six year experience with Federal Health it can be better informed and speak from a broader base of information than has been possible in the past. A Council of Academic Societies composed of faculty members from medical schools who were also representatives of established societies was envisioned in order to create a forum for faculty opinion and faculty representation in the AAMC. Faculties of medical schools should have an important formal position in the development of policies and positions of the AAMC and should participate in the formulation and announcement of all policies. Simple faculty representation would not take the AAMC beyond past efforts, whereas the idea of professional societies would provide some kind of unifying forum for the individual societies to come together and provide a basis for consideration of postgraduate training and continuing education programs in the future. Those present were not asked to conform to a fixed pattern but to suggest ways and means by which the AAMC could get faculty representation. Those present were asked to identify an organizing committee that would deal with the issues to be raised. The group was charged not to predict the formal, final membership, but to have enough representative quality so that it would be a reasonable group from which to arrive at a definition of the ultimate. The AAMC is a part of a university community which itself is rapidly changing. Just as a total university community finds itself organizing itself nationally, so must the AAMC as part of that community.

Dr. Philip P. Cohen stated that he thought the aims should be not to represent the faculties but rather the areas of activity with which the faculties identified. He felt that by encompassing all the different professional societies under a formal identification by saying the AAMC had a liaison of some type with them would be a sectarian view and such an umbrella approach to gain a loud voice for the AAMC would be unfortunate. He suggested only identification with medical school departments would have a meaningful impact on society -- an opportunity for the individual faculty member to define what his area is, how his area is represented. The scope and breadth of new thinking and fresh ideas would not come from the professional societies because they would defend their own positions and would not represent radical and bold ideas. He thought the AAMC should exploit those areas in the university that are not having an impact on medical schools today but would have in the future, such as engineering, schools of education, undergraduate programs, etc. He charged the approach as being sectarian by restricting the group to only those societies that represent the components of the medical faculty. He proposed a group of advisory councils: education methods and procedure, a research component, the clinical service function, and administration of education for the deans. He said it is important to get away from the idea of representing faculty and to represent those segments of interest which are identified as rallying points for those interested in teaching and research.

Dr. Jonathan Rhoads suggested that the representative side as outlined in the submitted report be a rotating group of people. He thought there would be relatively few people who would serve over two years, many perhaps a year. He suggested that that kind of a constituency was valuable as a feedback mechanism but cannot gain great power or authority as a put-in mechanism. He thought it would be useful to provide some sense of participation and keep a large number of key professional societies informed about what the AAMC was endeavoring to do, but it would need to be supplemented by a group of people who could serve on a longer term basis because of what they have to give. These people could be developed from the transient representatives of societies and some could be developed in other ways to provide an effective in-put. He suggested that people have to stay with a thing over a considerable period of time to be effective.

Dr. Ralph Wedgwood proposed that the Council be flexible so that stepwise they could incorporate the expanding role of the AAMC, expanding from a primary role or interest in the process of medical education, to that of the education of physicians and the education of health professions. He suggested a harder definition of the organizations that should be given representation on the Council be made. Organizations which should be represented should have as a primary requisite, that of an academic position on a University faculty. The organization must represent all of the universities involved in the process of medical education. He felt that department chairmen need to be involved in the AAMC council process.

Dr. Thomas Kinney suggested that by looking back to see who the past presidents of the various societies have been for the past 15 years, and by looking at their constitutions, organizations which might be included could be identified. He thought the important thing was to get on with a structure that would bring together men representing the various disciplines that are concerned with teaching in medical schools, problems relating to education, research, building, government, financing, etc. He said he found the Millis Report unacceptable and had the AAMC been more aggressive it would have been able to present a plan which would have been accepted. He advised everyone to keep an open mind, suggested the Council of Academic Societies would function all the way through the AAMC and said that no matter what was done at the meeting, even though it would be incomplete, it would be a start.

Dr. Robert Williams summarized the activities of the Association of Professors of Medicine, the Medical Intersociety Council, and the Research Societies Council.

Dr. Hubbard presented names proposed as an organizing committee, Dr. Thomas Kinney, Chairman pro tem, Drs. Jonathan Rhoads, James Warren, Philip P. Cohen, Morris Shaffer, and Ralph Wedgwood.

Dr. Robert E. Forster said he had some fundamental questions he would like answered before voting.

Dr. Hubbard moved that decision on the committee be deferred until after lunch and further discussion.

The meeting adjourned for lunch, at 12:30 p.m.
At 1:30 p.m. the discussion was resumed.

Dr. Robert E. Forster asked what sort of representation and control the professional societies and their representatives would have.

A discussion of some length ensued. It was decided the initial founding group should be small and representative of the major components of the faculties. There are no restrictions in preventing one of these people from becoming president of the AAMC. They should be distinguished in their fields and have membership in a distinguished society. The purpose of the CAS of the AAMC was defined as a forum in which the broadly represented consideration of medical educators could clarify attitudes and define responsibilities in guiding the development of local and national policies toward education in the universities, colleges, and medical centers, and in improving the health of the people.

A motion was made and carried that from this faculty group an organizing committee be formed with Dr. Thomas Kinney as Chairman pro tem, and other members of the committee being Drs. Rhoads, Warren, Cohen, Shaffer, and Wedgwood.

At 3:00 p.m. the meeting adjourned for coffee and was resumed at 3:20 p.m.

Twenty-two societies were represented by 44 individuals at the first meeting of the Council of Academic Societies on October 27, 1967. In addition to the adoption of a constitution and by-laws, the Council discussed what the parameters of its agenda should be.

"The Council should seek to develop an action role for itself. The Council should avoid any tendency to become a debating society at which nothing more was accomplished than speech making. Rather, the Council should address itself to problems that were general enough to concern many, not so global as to present the temptation to allow escape into dialectic, well enough circumscribed so that they were solvable and important enough so that the answer when arrived at would be worth having. The committee suggested that the most immediate problem on which this Council should focus its attention was the general area of health manpower. They further suggested that problems in faculty development would be a fruitful place for the Council to begin. Other areas of potential interest include the nature of the bottleneck preventing the rapid expansion of medical schools and some of the problems which the further interdigitation of residents into the programs of medical centers will occasion.

The first program of the Council of Academic Societies focused on The Role of the University in Graduate Medical Education. In his introduction to the three day conference in October 1968, Thomas Kinney, Professor and Chairman of Pathology at Duke and first CAS Chairman, told the Council:

"The CAS is now in a position to carry out its main objectives: (a) to bring the medical college faculty into more active participation in the programs of the AAMC, (b) to enhance the medical school faculties' awareness of the national scope of the demands made upon medical education, and (c) to serve as a forum in which faculty opinion is given recognition in the formulation of national policies in the whole span of medical education.

"The CAS, then, expects to be active in medical academic affairs. It is generally agreed that the 3 major areas of concern of the faculty of any medical center are: (a) the students, including their selection and the development of their intellectual and nonintellectual characteristics; (b) the curriculum, its content and methodology of presentation; and (c) the faculty itself, which includes the training, recruitment, and development of the faculty."

Growth and Development

In 1969 John Cooper became President and moved the Association to Washington, D.C. This transition enhanced the emphasis on AAMC's becoming a major voice in national policies affecting medical education, biomedical research, and medical care. For the Council of Academic Societies, a strong and persistent focus on biomedical research policy and funding evolved, and in the early 1970s the Division of Biomedical Research and Faculty Development was established with Michael Ball, immediate past President of the AFCR, as its first Director. That office has been the central focus of the CAS.

The plateauing and downturn of federal support for biomedical research and the reduction of research training opportunities have been major continuing concerns of the Council. The combined AAMC/CAS leadership in working to maintain the programs of the NIH has been a significant factor in the growth of membership of the CAS. Except for the resignation of a few large societies, such as the American College of Surgeons, the American Academy of Pediatrics, and the American Psychiatric Association, when dues were increased in 1973, the membership in CAS has grown steadily from 22 to 76 societies. Other national policy issues that member societies have looked to the CAS for action on are the clinical laboratory improvement act, medicare reimbursement of physicians in a teaching setting,

amendment of the National Labor Relations Act to permit unionization of house staff, and animal research legislation. Although medical education issues have been a part of many CAS programs, only one has caused widespread debate among member societies and that is the role of the National Board of Medical Examiners in certification for medical licensure and for medical student and medical education program evaluation.

Since the early 1970s the member societies of the CAS have been encouraged to become politically active in Washington, and to establish policies and procedures that will allow timely responses to legislative or regulatory challenges. Because the level of interest in political affairs by organizations fluctuates with the changing membership of their officers and governing boards, the CAS has encouraged member societies to designate a public affairs representative who has a continuing interest in public policy and who is the Council's contact when action is needed. Workshops were held on two occasions for these individuals to inform them of how both the legislative and executive branches of government function. In addition, a quarterly news sheet, the CAS Brief, informing societies of pending, legislative, or regulatory issues was initiated and CAS Alert messages have been issued from time to time when action is needed. The Brief was cancelled in 1983. All CAS society representatives and officers now receive the more timely Weekly Activities Report.

Increasing interest in having a "Washington presence" resulted in the formation of the Council of Academic Societies' Services Program in 1977. The Association of Professors of Medicine, four neurological societies, and the AFMR are clients of the program. However, a number of CAS member societies have opted to either hire Washington lobbyists or to use the lobbying functions of their national professional college or academy. There is little question

that this movement toward societies seeking their own voice in national policy will grow.

The AAMC - A Consensus Organization with a Centralized Governance

The restructuring of the AAMC which established three Councils could have resulted in a tripartite organization with each Council conducting its own affairs and carrying out its own programs with only modest overlap. Instead, the three Councils and the OSR have developed a mode of operation that presents all matters before the Executive Council to the Administrative Boards before final action is taken. The bulk of time of Administrative Board meetings is spent on items in the Executive Council agenda and most issues are resolved by consensus. Rarely have ad hoc committees composed entirely of members of a single Council been established and the only standing committee of the CAS is the nominating committee. Conversely, Association committees are always composed of representatives from all three Councils, although the balance of representation may vary depending upon the charge to the committee.

This mode of deliberation and governance has been successful. It has promoted unity of purpose and has allowed the three major elements of academic medical centers to speak with one voice. Administrative Board members have been privileged to examine issues of principal concern to the other Councils and have gained insight into the complexity of the biomedical education, research, and service enterprise.

However, this experience has not been extended to the representatives of CAS member societies to a significant degree. The letter on page 23 from the representatives of the Association of University Anesthetists expresses feelings that are probably shared by many CAS representatives. In the main, CAS representatives and their member societies are recipients of information from the AAMC rather than initiators of input to the AAMC.

A Diverse Constituency

Members of the Council of Deans and the Council of Teaching Hospitals hold their membership in those Councils by virtue of their professional positions. For both deans and teaching hospital executives, these are the principal national organizations that are concerned with their day to day interests and responsibilities. The CAS constituency is composed of diverse academic societies (see page 25) that appoint representatives to participate in the business of the Council, but the professional interests and responsibilities of these representatives are only tangential to the activities of the CAS and AAMC. Further, representatives rarely can speak for their societies because the timing of CAS meetings and the timing of member society meetings do not permit most societies to consider items on the CAS agenda in advance of a CAS meeting.

Things to Consider

1. What are the issues and concerns that should be considered in an examination of CAS activities, modes of operation, and future challenges?
2. What procedures should be followed?
3. What should be the time course?



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STANFORD UNIVERSITY SCHOOL OF MEDICINE
Department of Anesthesia

C. Philip Larson, Jr., M.D.
Professor of Anesthesia

November 25, 1983

Virginia V. Weldon, M.D.
Associate Vice Chancellor
Washington University School of Medicine
Box 8106, 660 S. Euclid Ave.
St. Louis, MO 63110

Dear Dr. Weldon:

We are writing to you in our capacity as representatives of the Association of University Anesthetists to the Council of Academic Societies. First, we would like to congratulate you on your election as Chairman of the CAS Administrative Board. We wish you every success in the coming year.

An additional purpose in writing to you is to express our concern over the administrative functioning of the CAS, a concern that we believe is shared by many representatives to the CAS. Basically, the CAS meets formally twice a year, the meetings consist primarily of presentations by AAMC officials or academic leaders, and the CAS representatives return home until the next meeting. There is virtually no dialogue or interaction between the CAS Administrative Board and CAS representatives either during the two meetings or in the long intervals between meetings. CAS representatives receive regular communications from the AAMC, but by and large, the policies are determined and the plans of action are in place by that time. From our vantage point, it would seem that the CAS has no policies, no programs and no advanced input into the decision-making of the AAMC. The CAS representatives do little more than listen and rubber stamp what has already happened. In truth, the CAS meetings are nothing more than information sessions.

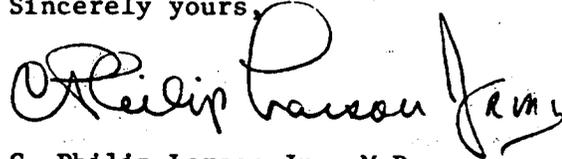
Even the business meetings of the CAS lack the realities of a business session. As one of many examples, the presentation at the most recent business meeting by the outgoing Chairman, Dr. Frank Wilson, was a thoughtful, scholarly, and intellectually challenging consideration of the subject of creativity, and it certainly deserves publication and wide review. However, it was presented at the wrong time and place. It should have been presented in the CAS morning program or among the general presentations of the AAMC. As a result of this and other presentations at business meetings, the agenda of the business meeting is always too full, there is little time for meaningful discussions of key issues among CAS representatives, and the representatives leave the business meeting without having developed any programs, policies or even a consensus on the major issues.

We believe that the CAS must modify the way it functions if it is to remain a viable entity by having a meaningful role in the future planning for academic medicine and the biomedical research enterprise. The CAS Administrative

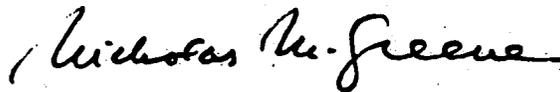
Board must find ways to increase the dialogue between itself and its member representatives. It must solicit the views of CAS representatives on key issues, propose policies or programs based on those views, attempt to develop consensus among the representatives for those policies or programs, or failing that at least articulate the major differing positions, and when consensus is reached, work toward implementation of those policies or programs through the AAMC. This may mean a restructuring of the CAS meetings, the periodic creation of subcommittees with defined tasks, or a variety of other alternatives. The AAMC cannot hope for unity and consensus among scientists if the CAS, a major and potentially influential scientific entity, does not even have a mechanism in place for developing either.

We offer this commentary and these suggestions in the spirit of and hope for an examination and discussion of the future role of the CAS. We believe that better mobilized and motivated, the CAS can be a more effective force in aiding the AAMC in presenting its programs and policies to Congress and the public.

Sincerely yours,



C. Philip Larson Jr., M.D.
Professor of Anesthesia
Stanford University School of Medicine



Nicholas M. Greene, M.D.
Professor of Anesthesia
Yale University School of Medicine

1983-84 Membership List for the Council of Academic Societies

BASIC SCIENCES

ANATOMY

American Association of Anatomists
Association of Anatomy Chairmen

BEHAVIORAL SCIENCE

Association for the Behavioral Sciences and Medical Education

BIOCHEMISTRY

American Society of Biological Chemists, Inc.
Association of Medical School Departments of Biochemistry

CELL BIOLOGY

American Society for Cell Biology

GENETICS

American Society of Human Genetics

MICROBIOLOGY

Association of Medical School Microbiology Chairmen

NEUROSCIENCE

Society for Neuroscience

PHARMACOLOGY

American College of Neuropsychopharmacology
American Society for Clinical Pharmacology and Therapeutics
American Society for Pharmacology and Experimental Therapeutics
Association for Medical School Pharmacology

PHYSIOLOGY

American Physiological Society
Association of Chairmen of Departments of Physiology

CLINICAL SCIENCES

ALLERGY

American Academy of Allergy

ANESTHESIOLOGY

Association of University Anesthetists
Society of Academic Anesthesia Chairmen

CLINICAL RESEARCH

American Association for the Study of Liver Diseases
American Federation for Clinical Research
American Society for Clinical Investigation
Central Society for Clinical Research
Plastic Surgery Research Council
Society for Gynecologic Investigation
Society for Pediatric Research

DERMATOLOGY

Association of Professors of Dermatology, Inc.

EMERGENCY MEDICINE AND CRITICAL CARE

Society of Critical Care Medicine
Society of Teachers of Emergency Medicine

ENDOCRINOLOGY

Endocrine Society

FAMILY MEDICINE

Association of Departments of Family Medicine
Society of Teachers of Family Medicine

GENERAL SURGERY

American Association for the Surgery of Trauma
American Surgical Association
Association of Academic Surgery
Society for Surgery of the Alimentary Tract, Inc.
Society of Surgical Chairmen
Society of University Surgeons

INTERNAL MEDICINE

American College of Physicians
Association of American Physicians
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
American Gastroenterological Association
American Society of Hematology

NEUROLOGY

American Academy of Neurology
American Neurological Association
Association of University Professors of Neurology
Child Neurology Society

NEUROSURGERY

American Association of Neurological Surgeons

OBSTETRICS AND GYNECOLOGY

American College of Obstetricians and Gynecologists
Association of Professors of Gynecology and Obstetrics

OPHTHALMOLOGY

American Academy of Ophthalmology
Association of University Professors of Ophthalmology

ORTHOPAEDICS

American Academy of Orthopaedic Surgeons
Association of Orthopaedic Chairmen

OTOLARYNGOLOGY

Association of Academic Departments of Otolaryngology
Society of University Otolaryngologists

PEDIATRICS

American Pediatric Society
Association of Medical School Pediatric Department Chairmen, Inc.

PHYSICAL MEDICINE AND REHABILITATION

American Academy of Physical Medicine and Rehabilitation
Association of Academic Physiatriests

PLASTIC SURGERY

American Association of Plastic Surgeons
Plastic Surgery Educational Foundation

PSYCHIATRY

American Association of Chairmen of Departments of Psychiatry
American Association of Directors of Psychiatric Residency Training
American Psychiatric Association
Association of Academic Psychiatry
Association of Directors of Medical Student Education in Psychiatry

RADIOLOGY

Association of University Radiologists
Society of Chairmen of Academic Radiology Departments

THORACIC SURGERY

American Association for Thoracic Surgery
Thoracic Surgery Directors Association

UROLOGY

Society of University Urologists

HEALTH AND HUMAN VALUES

Society for Health and Human Values

PATHOLOGY AND CLINICAL LABORATORIES

Association of Pathology Chairmen, Inc.
Academy of Clinical Laboratory Physicians and Scientists

PREVENTIVE MEDICINE

Association of Teachers of Preventive Medicine

Status of Research Facilities and Instrumentation

Background. The continuing deterioration in the quality of research facilities and instrumentation in the academic laboratories, including those in medical centers, has become a matter of increasing concern to scientists, institution officials, and those science-oriented agencies within the Federal government responsible for science programs. A major constraint to prompt and sound planning to contend with this problem has been the absence of timely information as to the quantitative and qualitative dimensions of these research resources.

At the time of the June 1981 Executive Council meeting, the decision was made to establish an ad hoc committee to examine issues relating to the funding of research resources. This was prompted by a number of considerations, including concerns about the quality and quantity of instrumentation in academic institutions, increasing competition for available funds, and some uncertainty with respect to the future within NIH of the Division of Research Resources. No meeting of that committee was ever convened, in part because the threat to the continuing existence of DRR disappeared, and because it seemed that more comprehensive examination of these issues would be undertaken by organizations with a broader base than the Association.

Since that time, the concerns about the underlying problem have continued to grow, and several studies have been initiated or proposed in the two areas. They are summarized as follows.

(1) National Survey of Academic Research Instruments and Instrumentation Needs. Sponsored and supported by the National Science Foundation and NIH, and conducted by WESTAT, Inc., the purpose is to "provide a factual basis for the review of Federal equipment funding levels and priorities. This survey will document for the first time: (a) trends in the amount, condition and cost of existing research instrumentation in the nation's principal research universities and medical schools, and (b) the nature and extent of the need for upgraded or expanded research instrumentation in the major fields of academic science and engineering." The study involves a nationally representative sample of 43 major R&D universities and a partially linked sample of 24 medical schools. Information will be collected on a representative sample about each type of research instrument's age, cost, means of acquisition, condition and so forth. The findings will be used to develop quantitative indicators of trends over time and differences among fields in instrumentation costs, investment, condition, and need. The study will be conducted over a two-year period that commenced late in 1982. Medical schools will be involved only in 1983-84. (See page 33)

(2) A Project to Assess and Disseminate Alternative Approaches to Meeting University Research Equipment Needs. Originally supported

by NSF, DOA, DOD, DOE and NASA and carried out by AAU, NASULGC and COGR, this is a 16-month project, with the objective of "increasing awareness among research universities of opportunities for better planning and management of research equipment at all levels." The project is planned in three phases. In phase I, six analyses will be conducted to:

- Assess the role of debt-financing of research equipment and sound university financial practice;
- Identify and evaluate opportunities to improve the procurement, management, use, operation and maintenance of research equipment;
- Assess present tax incentives for the donation of research equipment and suggest ways to increase support from the private sector;
- Identify opportunities to eliminate or reduce state and university budget and policy barriers;
- Identify opportunities for changes in Federal regulations;
- Evaluate present methods of direct Federal investment and suggest improvements.

Phase II involves regional seminars to disseminate and discuss the results of the six analyses within the university community. The third phase is a briefing in Washington to present to Federal agencies and Congress the results of these analyses.

Apparently during the planning phase there was some confusion about the possibility of NIH also being a supporter of the project. As a consequence, there was no specific biomedical aspect to the study. Because of that, AAMC staff expressed their concern about this seemingly unnecessary and serious defect. Negotiations were therefore reopened with NIH, with the result that partial funding for part of the project to add a biomedical component has been assured. The project is to be completed in February 1985. (See page 37)

(3) Interagency Study of Academic Science and Engineering Laboratory Facilities. The House version of the Authorization bill for the Department of Defense for FY 1984 included the following provision: "The Committee also directs that a study be undertaken by the Secretary of Defense on the need to modernize university science laboratories essential to long-term national security needs. The study should be submitted to the Committee by March 15, 1984." The Congress also directed NSF to be a lead agency in encouraging other Federal agencies, state and local governments, and the private sector to support renewal of university research facilities. A steering committee was formed with representatives

from NSF, DOD, NIH and DOE to plan a study of such facilities. The objective is to obtain an understanding of the condition of university facilities currently being used for science and engineering research and the estimated future needs for construction, remodeling and refurbishment.

A request has just been directed to the chief executives of approximately 25 institutions asking for 5-year facility plans and estimated expenditures for new construction and remodeling of existing structures over that period. The purpose of this request is to assist the steering committee in its planning of the study and the preparation of an interim response to the Congress. (See page 41)

No further details are available at the moment, except for the expectation that most research-intensive universities will be included in the final survey population. AAMC has urged that the planning for the study be certain to include recognition of the unusual circumstances of teaching hospitals with sizeable research programs.

(4) Legislative Incentives.

- S. 1537. Senators Danforth and Eagleton introduced S. 1537 last year, a bill which provides additional authorizations for appropriations for FY 1984 and each of the four following years with the goals of (1) strengthening support for fundamental research in science and engineering, (2) upgrading, modernizing and replacing university research equipment, (3) providing increased numbers of graduate fellowships, (4) supporting faculty career initiation awards, (5) supporting efforts to rehabilitate, replace or improve university research facilities, and (6) supporting modernization and improvement of undergraduate science education.

The authorized sums are specified for DOA, DOD, DOE, NASA and NSF, whereas for NIH the bill states "... those additional amounts necessary to restore the capacity of NIH to conduct and support adequate levels of biomedical research." The yearly authorized sums for the other five agencies total \$139 million/year for acquisition, installation or modification of research instrumentation and \$245 million available on a matching basis for programs to modernize, rehabilitate, replace, or improve existing university research facilities.

The sponsors of the Senate Bill now plan to introduce this subject in the House. Since S. 1537 was not intended to pass as a separate Bill, but to express a sense of the Senate about the urgent need to support the Nation's university research capability and to influence the outcome of the Appropriations Bills, it is possible that

a Resolution will be introduced in the House and passage of a Joint Resolution sought.

The objectives of this legislative proposal are highly commendable, but insofar as biomedical research and the NIH are concerned, two difficulties remain to be resolved. The first is the complication of introducing the concept of an authorization ceiling for NIH at the very time when we are vigorously opposing that concept in legislation directed more specifically at the NIH. The second, more pertinent to the facilities and instrumentation issues, is that NIH no longer has broad constructive authority on which any program for major construction or renovation of facilities might have to be based.

• H.R. 2350. One of the provisions of the House bill to reauthorize parts of the NIH, H.R. 2350, requires a study "concerning the use of live animals in biomedical and behavioral research." One component of that proposed study reads as follows:

"Estimate:

(A) the amounts that would have to be expended by entities which conduct biomedical and behavioral research with Federal financial assistance to equip and modernize their research facilities in order to meet the standards referred to in paragraph (2); and

(B) The amounts that would be expended by entities which have not previously conducted such research with Federal financial assistance to establish, modernize, or equip facilities in order to meet such standards."

Other legislative initiatives have included the well-publicized efforts of several universities to obtain money for construction of research facilities through special-interest amendments in Congress. AAU, NAS, APS and AAAS have published statements strongly critical of that tactic, which bypasses the peer review processes of the scientific community and prospective funding agency.

(5) Current Mechanism for Funding Capital Improvements. Under OMB Circular A-21 it is possible to include depreciation or user charges for space and interest charges on money borrowed for major capital improvements in the indirect cost pool. The extent to which this mechanism is presently being employed is unknown.

Recommendations. The Association should:

1. urge its members to cooperate insofar as possible with any of the studies which are described above,
2. delay any further action as to additional surveys or other studies until the reports and analyses of the studies presently underway or pending are completed, and
3. monitor closely the progress and outcome of these studies.

National Science Foundation
and National Institutes of Health

NATIONAL SURVEY OF ACADEMIC RESEARCH
INSTRUMENTS AND INSTRUMENTATION NEEDS

Purpose of the Study

In recent years, widespread concern has developed about whether university-based scientists have sufficient access to the kinds of equipment needed to support continuing research at the frontier of scientific knowledge. To provide a factual basis for review of Federal equipment funding levels and priorities, this survey will document for the first time: (a) trends in the amount, condition and cost of existing research instrumentation in the nation's principal research universities and medical schools, and (b) the nature and extent of the need for upgraded or expanded research instrumentation in the major fields of academic science and engineering (S/E).

Research Strategy

The study is being conducted at a nationally representative sample of 43 major R&D universities and at a partially linked sample of 24 medical schools. At sampled institutions, data are being collected from administrators of S/E departments and nondepartmental research facilities about the adequacy of existing research equipment and about equipment needs and priorities.

In connection with this department/facility survey, representative samples of existing research instruments will be selected and information will be collected about each instrument's age, cost, means of acquisition, condition, etc. The findings will be used to develop quantitative indicators of trends over time and differences among fields in instrumentation cost, investment, condition, and need.

Several features of the study are designed to minimize response burden for participating universities and medical schools:

- The study will be conducted over a two year period. In 1982-83 (Phase I), data will be collected for the physical sciences and engineering/computer science; then in 1983-84 (Phase II), similar data will be collected for the biological, agricultural and environmental sciences. Medical schools will be involved only in 1983-84.

- The instrument survey component will be limited to samples of research instruments with original purchase cost of \$10,000-\$1,000,000, excluding equipment in university-administered Federally Funded Research and Development Centers. In addition, very limited information will be obtained about very large instrument systems costing over \$1 million.

- Wherever possible, the university's computerized central property inventory will be used to create the department/facility instrument lists from which the instrument samples will be drawn.

- In situations where a university has a large number of departments in a particular field or where a department has a large amount of research equipment, representative samples of departments and/or instruments will be selected. In each phase, the survey will encompass an average of 7.5 departments per institution and 15.5 instruments per department.

Project Administration

This study is being administered by Westat, Inc., under contract to NSF and NIH. The NSF Project Officer is James Hoehn (202) 634-4673. The NIH Project Officer (for medical school component) is Charles Sherman (301) 496-4418. The principal investigator at Westat is Kenneth Burgdorf; the Westat survey coordinator and university liaison is Howard Hausman. The latter individuals can be reached at (301) 251-1500 or, at:

Westat, Inc.
1650 Research Boulevard
Rockville, MD 20850

Project Schedule

Nov. 1982. Identify nationally representative sample of 43 universities.

Dec. 1982 - Jan. 1983. Develop Phase I data collection arrangements at selected institutions.

Feb. - March 1983. Obtain instrument inventories for sampled departments in physical sciences, computer science and engineering; identify instrument sample.

Apr. - May 1983. Obtain inventory corrections, department questionnaires and instrument data sheets at sampled departments.

June - Sept. 1983. Process and analyze data; revise procedures as needed; select medical school sample.

Nov. - Dec. 1984. Begin Phase II. Obtain instrument inventories for sampled departments in biological, agricultural and environmental sciences.

Jan. - mid April 1984. Obtain department questionnaires and instrument data sheets from Phase II departments.

May - Oct. 1984. Process and analyze data; publish findings and recommendations.

Sample of Medical Schools

A sample of 24 medical schools has been selected for the NIH component of the NSF/NIH National Survey of Academic Research Instruments and Instrumentation Needs. Medical schools were selected based on total awards as shown in the Summary of NIH FY 1982 Extramural Awards to Medical Schools. This total includes five kinds of NIH awards: research grants; contract; fellowships and training grants; cancer control grants; and other awards.

The sample was restricted to medical schools with at least \$3,000,000 in total NIH awards in FY 1982; the 92 schools in this "frame" account for 97 percent of all NIH awards to U.S. medical schools. Six schools were selected from each of 4 strata, as defined below. The selection procedure was one that maximized overlap with the original NSF institution sample.

Description of sampling strata

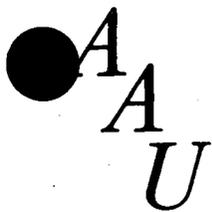
<u>Stratum</u>	<u>Definition</u>	<u>Total NIH awards</u>	<u>No. Sampled</u>	<u>Sampling rate</u>
1	Top 8 awardees	\$ 381,818,000	6	75%
2	Next 12 awardees	385,805,000	6	50%
3	Next 18 awardees	352,478,000	6	33%
4	Next 54 awardees	388,383,000	6	11%
Total	92	1,508,444,000	24	-

List of Medical Schools, by stratum, based on
FY 1982 NIH extramural awards

<u>NIH rank</u>	<u>Stratum 1 (\$43.6-55.7 million)</u>	<u>Overlaps NSF Sample</u>
1	University of California at San Francisco School of Medicine	No
2	Yale University School of Medicine	Yes
4	Johns Hopkins University School of Medicine	Yes
5	Albert Einstein College of Medicine, Yeshiva University	No
7	University of Pennsylvania School of Medicine	Yes
8	University of Washington School of Medicine	No
<u>Stratum 2 (\$25.0-36.6 million)</u>		
11	Duke University School of Medicine	Yes
12	University of California at Los Angeles School of Medicine	Yes
13	University of Chicago Pritzker School of Medicine	No
15	University of Minnesota Medical School at Minneapolis	Yes
19	University of California at San Diego School of Medicine	Yes
20	University of Texas Health Science Center, Southwestern Medical School (Dallas)	No
<u>Stratum 3 (\$13.5-24.3 million)</u>		
21	University of North Carolina School of Medicine	No
24	Mayo Medical School (Foundation)	No
27	Boston University School of Medicine	No
32	University of Colorado School of Medicine	Yes
36	University of Texas Health Science Center San Antonio Medical School	No
37	University of Cincinnati College of Medicine	No
<u>Stratum 4 (\$3.1-13.4 million)</u>		
43	Northwestern University Medical School	Yes
45	Temple University Medical School	Yes
61	Ohio State University College of Medicine	Yes
76	University of Kansas School of Medicine	Yes
87	University of Nebraska College of Medicine	No
91	Medical College of Ohio at Toledo	No

Public vs. Private breakdown of medical school frame and sample, by stratum

	Total	Stratum			
		1	2	3	4
<u>Frame</u>					
Total	92	8	12	18	54
Public	51	2	5	9	35
Private	41	6	7	9	19
Percent private	45%	75%	58%	50%	35%
<u>Sample</u>					
Total	24	6	6	6	6
Public	13	2	4	3	4
Private	11	4	2	3	2
Percent private	46%	67%	33%	50%	33%



Association of American Universities

A PROJECT TO ASSESS AND DISSEMINATE ALTERNATIVE APPROACHES TO MEETING UNIVERSITY RESEARCH EQUIPMENT NEEDS

The deterioration and obsolescence of scientific equipment in our nation's universities are widely recognized. In 1982 the Deputy Director of the National Science Foundation estimated the cost of updating university laboratories to be between \$1 billion and \$4 billion. Recent studies and reports have documented this erosion of our research base and the serious threat it poses to our economic welfare, international competitiveness, and national security.

Sustained federal investments in research equipment are essential. But in these times of fiscal constraint, all alternative approaches must be fully examined. Promising new and innovative ideas must be analyzed and tested for potential application to the university setting. If new ways to maximize the return on investments of our scarce financial resources can be developed, their use should be encouraged. If the management, use, and maintenance of equipment can be improved, these improvements must be documented and disseminated to the university community. Regulatory and policy barriers that remain in federal agencies, state governments, and universities must be identified and, where possible, eliminated.

In recognition of this need, the Research Corporation and five federal agencies--the National Science Foundation, the Department of Agriculture, the Department of Defense, the Department of Energy, and the National Aeronautics and Space Administration--will support a 16-month project to increase awareness among research universities of opportunities for better planning and management of research equipment at all levels. The project will be carried out under the leadership of the Association of American Universities, the National Association of State Universities and Land-Grant Colleges, and the Council on Governmental Relations.

A Steering Committee chaired by Richard A. Zdanis, a physicist and Vice Provost of Johns Hopkins University, will provide overall guidance to the project. A complete list of committee members and association representatives is attached.

The project is planned in three phases. In Phase I six analyses will be conducted to:

- *assess the role of debt financing of research equipment in sound university financial practice;
- *identify and evaluate opportunities to improve the procurement, management, use, operation and maintenance of research equipment;
- *assess present tax incentives for the donation of research equipment and suggest ways to increase support from the private sector;
- *identify opportunities to eliminate or reduce state and university budget and policy barriers;
- *identify opportunities for changes in federal regulations;
- *evaluate present methods of direct federal investment and suggest improvements.

Leading higher education associations and science and engineering societies will be invited to join the project as cooperating organizations. During Phase II they will be asked to host special seminars as part of regularly scheduled meetings of their members to disseminate the results of the six analyses. Several workshops will be held in the various regions of the country. Universities will be invited to send teams representing research faculty, administrators, finance specialists, legal counsels, and others to explore the opportunities that might be identified during Phase I and the policy implications and practical concerns posed by suggested approaches.

Current planning calls for a third phase, which will be a briefing in Washington, D.C. to present to federal agencies and Congress the results of the six analyses, as perfected by the seminars and workshops. The analyses and the findings and recommendations of the study will be published in a final report at the completion of the project.

NATIONAL SCIENCE FOUNDATION

WASHINGTON, D. C. 20550

January 5, 1984



OFFICE OF THE
DIRECTOR

Dear

In recent years, Federal Agencies and the Congress have received many expressions of concern that deteriorating research facilities are becoming a serious problem for university scientists and engineers, materially impairing their ability to work competitively at the frontiers of scientific and engineering knowledge. The House Authorization Act for the FY 1984 Budget of the Department of Defense directed that a study be undertaken by the Secretary of Defense on the need to modernize university science and engineering laboratories essential to long-term national security needs. The Congress also directed NSF to be an aggressive lead agency in encouraging other Federal agencies, state and local governments, and the private sector to support the renewal of university research facilities. Moreover, during the past 30 years NIH has provided major support for health facilities construction, and the Congress has periodically requested assessments of the status and needs for these facilities.

To respond to these concerns, a steering committee formed with representatives from NSF, DOD, NIH, and DOE is planning a study of university research facilities. The objective of the study will be to obtain an understanding of the condition of university facilities currently being used for science and engineering research and the estimated future needs for construction, remodeling, and refurbishment.

Discussions with a number of university presidents indicated that their institutions already had prepared five-year facility plans and detailed figures on expenditures for new construction and the remodeling and refurbishment of existing structures over the past five-year period and are willing to share the information with the committee. Thus, we believe that sufficient information already exists in the research universities to allow the steering committee to plan the study and to prepare an initial response to Congress. Accordingly we are writing to ask for your cooperation in supplying us with a copy of your current five-year (or equivalent) facility plans and any existing reports which contain information on new construction, remodeling, etc. during the past five years. Please send these materials to M. Kent Wilson, Room 305, National Science Foundation, Washington, DC 20550. We would appreciate receiving these reports by February 1, 1984.

2.

The information submitted by your institution will be treated as confidential and will not be released or published without your permission except in aggregated statistical form. A copy of the published report will be mailed to each responding institution.

We appreciate your cooperation.

Sincerely,

Richard S. Nicholson
Acting Deputy Director

JAN - 5 1984

LIST OF LEADING RESEARCH INSTITUTIONS

Dr. Steven Muller
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Johns Hopkins University
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Baltimore, MD 21218

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Dr. Irving Shain
Chancellor
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Madison
158 Bascom Hall
500 Lincoln Drive
Madison, WI 53706

Dr. Richard Atkinson
Chancellor
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Dr. Harold P. Shapiro
President
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Dr. C. Peter Magrath
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Dr. Donald Kennedy
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Dr. Frank H. T. Rhodes
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1200 Moursund Avenue
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Robert Buchanan, M.D.
General Director
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Boston, Massachusetts 02114

1984 CAS INTERIM MEETING PLANS

At its September 1983 meeting, the CAS Administrative Board scheduled the 1984 Interim Meeting for April 10-11. The meeting will be held in conjunction with the Administrative Board meeting already planned for April 11-12.

At a time when the future directions of the CAS are being discussed (see page 14), the CAS Board might consider structuring the Interim Meeting in such a way that the CAS Representatives in attendance would have the opportunity to identify: 1) the key issues which will confront medical school faculty in the next five years, and 2) the manner in which the CAS should in function in order to most effectively address these issues. The following program and format is offered for the Board's consideration:

April 10

10:00 am

PLENARY SESSION

"How Can Academic Medical Centers be Styled to Meet their Mission?"

Keynote Speaker

Additional Speakers to Address:

- 1) the organization and governance of Academic Medical Centers
- 2) the leadership needed in the areas of education, research, and medical service
- 3) the place of the medical center in the university

12:30 pm

LUNCHEON

2:00 pm

WORKSHOPS TO EXPAND UPON THEMES DEVELOPED IN THE MORNING PLENARY SESSION

4:00 pm

RECONVENE TO DISCUSS CONCLUSIONS REACHED DURING WORKSHOPS

5:00 pm

RECEPTION

April 11

8:00 am

OPEN DISCUSSION

If the key issues which will confront medical school faculty in the next five years can be identified during the first day of the meeting, the second day could be devoted to a discussion of how the CAS should function to effectively address these areas of concern.

11:30 am

Adjournment

The meeting focus and format outlined above would provide the opportunity for the Representatives to the CAS to offer guidance to the Administrative Board and

AAMC staff. Such an approach might effectively address some of the concerns outlined in the letter from two CAS Representatives which begins on page 23.

If the Board finds this meeting concept appealing, possible speakers should be discussed.

STRATEGY FOR THE BROAD DISSEMINATION OF THE AAMC DOCUMENT
OF PRINCIPLES FOR THE SUPPORT OF BIOMEDICAL RESEARCH

The necessity for periodic renewal of the legislative authorities for the Cancer and Heart Institutes presents an almost irresistible opportunity for the Congress to adopt into law provisions that would further diminish the managerial flexibility of the NIH leadership. The Association has been concerned that legislation containing highly specific directives (e.g., new institutes, task forces, set asides) may serve to hamper the productivity of the NIH. Therefore, the Association prepared and has distributed widely a document that presents its views regarding the management and funding of the NIH operation. The document, entitled "Preserving America's Preeminence in Medical Research: Principles for the Support of Biomedical Research," is enclosed with this agenda. The CAS Administrative Board suggested that endorsement of the statement by CAS societies would serve to enhance its impact. Therefore, the presidents of all CAS societies have been asked to review the document with their governing boards and consider adopting it as a formal position of their respective organizations. To date, 10 societies have indicated official support for the statement. Another 5 have notified staff of their intention to consider formal adoption at upcoming meetings.

The Executive Council and staff recognized that an ongoing strategy should be implemented to enlist the broadest possible support for the principles outlined in the position statement. It will be necessary to persuade some members of the scientific community, the professional and lay leadership of numerous voluntary health organizations, as well as members of Congress that the quickest, least expensive, and most effective route to their categorical objectives lies in the preservation of the traditional broad research authority of the Public Health Service Act, unencumbered by specific directives or details. Thus, the development and dissemination of a position statement was merely an important first step in a strategy to garner support for the principles which should underly the management and funding of the NIH. Additional components of such a strategy are outlined on the following pages.

As noted on pages 50 - 51, the CAS Administrative Board has already expressed interest in coordinating an effort to approach the leadership of important voluntary health organizations and encourage their adherence to the principles outlined in the blue position statement. A listing of many of these organizations begins on page 52. The CAS Board is asked to review the list and advise staff regarding:

- 1) any organizations that should be added to or deleted from a final listing of organizations that will be approached, and
- 2) the identification of key individuals to make initial contact with the groups.

In addition, the Board should consider how a greater number of CAS societies can be persuaded to consider endorsing the "statement of principles."

STRATEGY ON NIH LEGISLATION

Background

The emergence of forces that purposely or inadvertently portend decidedly threatening changes in the successful patterns of funding and managing the nation's biomedical research endeavor and its principal instrument, the National Institutes of Health (NIH), suggests the need for the development and adoption of a cooperative strategy to contend with these influences.

The contemporary problem has been described as follows in the Association's paper on biomedical research:

The evolution of the National Institutes of Health (NIH) into the world's most productive and prestigious biomedical research enterprise has been one of the important and remarkable developments in this country during the post-World War II period. Recent events suggest the favorable conditions that contributed to that phenomenon are changing. Most prominent among the forces influencing that change has been a significant modification in approaches to legislation under which the NIH has been funded and managed. Spurred in large part by dissatisfaction with funding levels for NIH programs in their areas of interest, both lay and professional leaders of many disease-oriented organizations have turned increasingly over the last decade to a responsive Congress. They have adopted a strategy of proposing new legislation as a means of satisfying their aspirations for greater visibility and support. This approach is epitomized by bills currently before the Congress that contain numerous specific directives to NIH which, if passed, would attain the relative permanence of statute. Conversely, the components of the NIH itself are moved toward relative impermanence because of the need for periodic renewal of expiring legislative authorities, such as those for the Cancer and Heart Institutes. Given the almost infinite number of potential disease oriented causes and the predictable competition among them for greater recognition, this circumstance creates a continuing opportunity for the expansion of set-asides, institutes, boards, task forces and programs. Over time, such legislation would create the antithesis of the broad, elegant authority for biomedical research, unencumbered by detailed directives, as enacted in 1944. The consequence would be an inevitable erosion and ultimately the destruction of the delicate balance between the political and scientific forces that has been and remains so crucial to the success of NIH.

Some Components of a Possible Strategy

The following is not intended to constitute an all-inclusive list of components, but to stimulate discussion. Because of the complexity of the issues and the sizable and diverse number of individuals and organizations who would be involved, the coordination and implementation of an appropriate strategy become particularly important. Similarly, timing--with respect to the implementation of the specific components of whatever strategy is agreed upon--would be especially crucial.

- Preparation and dissemination of a "white paper" embodying the principles and conditions required for a national research enterprise to flourish.

Such a document was requested by the Executive Council of the Association of American Medical Colleges and was adopted at the September, 1983 meeting of the Council. It has now been distributed within the constituency and to members of Congress.

- Establishment of a discussion/strategy group.

Such an organization should be informal and proposed to be broadly representative of organizations and individuals concerned about NIH but not unwieldy in size. It should be responsible for developing, disseminating and implementing an appropriate strategy.

- Enlistment of advisors.

Because of the complexities and other difficulties associated with such a venture, it would seem important to obtain the advice of individuals experienced in the Congressional process and in the operation of the NIH. Ex-Congressman Richard Bolling, former Assistant Secretary for Health Theodore Cooper, and former NIH Director Donald Fredrickson are examples.

- **Meetings with appropriate members of Congress and the Executive Branch.**

Periodic exchanges with Congressional leaders and with officials at different levels in the Executive Branch could serve to lessen the pressures for detailed legislation. Offers of assistance for carefully crafted oversight hearings, for briefings by Administration and agency officials of public interest groups and for discussion sessions could prove attractive.

- **Continuing compilation and analysis of legislative proposals.**

The most likely peril to the research enterprise is the consequence of cumulative legislative acts, no one of which by itself is destructive but which in the aggregate over time would slowly erode or eliminate the characteristics that made the NIH operation world prominent. Thus single provisions of a bill or any bill in its entirety should not be viewed in isolation but in context with existing statutes and other legislative proposals.

- **Review with professional societies and voluntary health organizations the ultimate consequences of detailed legislation for their causes and the NIH as a whole.**

The stimulus for many of the detailed legislative proposals frequently has arisen from within either the professional or lay elements of particular categorical interests. Thus the success of any effort to modify significantly the new legislative approach will depend on the ability to convince such individuals of the deleterious consequences to their cause of that approach over time. Obviously, the identification of key figures in such groups and a carefully coordinated and sympathetic approach to them would be a keystone in any such effort. The Administrative Board of the Council

of Academic Societies have already indicated their desire and willingness to participate prominently in any such effort and has been asked to do so.

- **Urge the leaders of these organizations and their representatives to concentrate their efforts on the appropriation process.**

As previously noted, most evidence indicates that the prime motivation for seeking legislative recognition lies in the perception that insufficient funds have been devoted to research on identified diseases or conditions. At the same time, the recent successes of very broadly based coalitions supporting higher appropriations for the NIH suggest that a decoupling of efforts directed towards the authorization process with greater attention directed to appropriations could be successful in avoiding the predicted consequences of the new legislative approach. Concomitantly, the funding prospects for biomedical research in general and disease causes in particular, could be enhanced.

VOLUNTARY HEALTH GROUPS

Alzheimer's Disease and Related Disorders Association
Amyotrophic Lateral Sclerosis Society of America
National Amyotrophic Lateral Sclerosis Foundation
Cooley's Anemia Foundation
American Juvenile Arthritis Organization
Arthritis Foundation
Asthma and Allergy Foundation of America
National Foundation for Asthma
National Society for Autistic Children
American Foundation for the Blind
National Association for Visually Handicapped
National Federation of the Blind
National Retinitis Pigmentosa Foundation
National Society to Prevent Blindness
Brain Research Foundation
American Brittle Bone Society, Inc.
American Cancer Society
United Cerebral Palsy Association, Inc.
March of Dimes Birth Defects Foundation
National Easter Seal Society
National Sudden Infant Death Syndrome Foundation
Cystic Fibrosis Foundation
International Cystic Fibrosis Foundation
American Diabetes Association
Joslin Diabetes Foundation
Juvenile Diabetes Foundation
Down's Syndrome Congress
National Association for Down's Syndrome
Dysautonomia Foundation, Inc.
Dystrophic Epidermolysis Bullosa Research Association of America
Epilepsy Foundation of America
National Genetics Foundation
Gerontological Society of America
American Heart Association
National Hemophilia Foundation
Committee to Combat Huntington's Disease
National Huntington's Disease Association
National Foundation for Ileitis and Colitis, Inc.
American Association for Clinical Immunology and Allergy
National Committee on the Treatment of Intractable Pain
National Kidney Foundation
Leukemia Society of America
American Hepatic Foundation
American Liver Foundation
American Lung Association
Lupus Erythematosus Foundation
Lupus Foundation of America
National Lupus Erythematosus Foundation
American Association for Maternal/Child Health

VOLUNTARY HEALTH GROUPS (CONT'D)

American Association on Mental Deficiency
National Association of Retarded Children
National Multiple Sclerosis Society
Muscular Dystrophy Association, Inc.
Myasthenia Gravis Foundation
National Committee for Research in Neurological and Communicative Disorders
United Ostomy Association
American Laryngological, Rhinological and Otological Society
American Speech-Language-Hearing Association
Deafness Research Foundation
National Association for Hearing and Speech Action
Paget's Disease Foundation
American Parkinson's Disease Association
National Parkinson Disease Association, Inc.
National Parkinson Foundation
United Parkinson Foundation
Population Association of America
National Psoriasis Foundation
American Public Health Association
National Reye's Syndrome Foundation
American Rheumatism Association
United Scleroderma Foundation
National Association for Sickle Cell Disease, Inc.
Spina Bifida Association of America
National Spinal Cord Injury Foundation
Stroke Foundation, Inc.
National Foundation for Jewish Genetic Diseases
National Tay-Sachs and Allied Diseases Association, Inc.
Tourette's Syndrome Association, Inc.
National Tuberos Sclerosis Association
Tuberous Sclerosis Association of America

FUTURE MEETING DATES

CAS Administrative Board Meeting Dates (1984)

April 11-12

June 27-28

September 12-13

AAMC Annual Meeting Dates

1984 - October 27 - November 1 (Chicago, Illinois)
CAS meetings tentatively scheduled for October 28 and 29

1985 - October 26 - 31 (Washington, D.C.)
CAS meetings tentatively scheduled for October 27 and 28

1986 - October 25 - 30 (New Orleans, Louisiana)
CAS meetings tentatively scheduled for October 26 and 27

CAS Interim Meeting

April 10-11, 1984 (preceding the CAS Administrative Board meeting)