COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 27, 1984

5:00 p.m. CAS/COD JOINT ADMINISTRATIVE BOARDS MEETING — Conservatory Room

The Use of Animals in Research

Guests: Charles R. McCarthy, M.D.
Director
Office for Protection from Research Risks
NIH

John F. Sherman, Ph.D.
Vice President, AAMC
President, National Society for Medical Research

Discussion will center on:

- the current sociopolitical climate characterized by increasing efforts to restrict the use of animals in research
- recent NIH activities in education of scientists and the public and in examination of NIH policy on Laboratory Animal Welfare
- participation by scientists and scientific societies in efforts to minimize restrictions on animal research
- the Boards will have an opportunity to view a brief videotape prepared for public education by the California Biomedical Research Association

(see page 53)

7:00 p.m. CAS/COD RECEPTION — Farragut Room

7:45 p.m. CAS/COD DINNER — Conservatory Room

June 28, 1984

9:00 a.m. CAS ADMINISTRATIVE BOARD MEETING — Independence Room

1:00 p.m. JOINT ADMINISTRATIVE BOARDS LUNCHEON — Hemisphere Room

2:30 p.m. ADJOURNMENT

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 27-28, 1984

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

April 11-12, 1984
Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members

Robert L. Hill, Chairman (Presiding)
Philip C. Anderson
Bernadine H. Bulkley
David H. Cohen
William F. Ganong
Harold S. Ginsberg
Joseph E. Johnson
Douglas Kelly
Jack L. Kostyo
Frank G. Moody
Virginia V. Weldon
Frank C. Wilson

Staff

John A. D. Cooper *
Carolyn Henrich
Thomas J. Kennedy *
Richard M. Knapp *
Lynn Morrison *
John F. Sherman *
Elizabeth M. Short
August G. Swanson *
Lucy Theilheimer *

Guests

Pamelyn Close
John C. Crowley
Helen H. Gee
Richard Janeway
Donald G. Langsley
Carol R. Scheman

The CAS Administrative Board convened on April 11 at 2:30 p.m. for a business meeting. At 4:30 p.m., the Board was joined by Dr. Helen Gee, Mr. John Crowley, and Ms. Carol Scheman for a discussion of the state of institutional research facilities and instrumentation (see page 2). The meeting adjourned at 6:30 p.m. for a social hour followed by dinner at 7:30 p.m.

The CAS Administrative Board reconvened at 9:00 a.m. on April 12 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 the meeting

I. STATUS OF RESEARCH FACILITIES AND INSTRUMENTATION

Dr. John Sherman provided an overview of this issue, emphasizing the growing concern regarding the deteriorating quality of the research facilities and instrumentation in academic laboratories. He noted that several studies had been initiated to assess facility and equipment needs. There had been general agreement among organizations representing the academic community that the results of these studies should be reviewed prior to the initiation of efforts to secure necessary funding.

For further discussion of this issue, the Board was joined by Dr. Helen H. Gee, chief of the NIH Program Evaluation Branch; Mr. John C. Crowley, director for federal relations for science at the Association of American Universities; and Ms. Carol R. Sheman, Director of Federal Relations for Health and Biomedical Research at the Association of American Universities. Dr. Gee discussed a two-year study, jointly sponsored by the NIH and the National Science Foundation, to determine the condition of existing instrumentation and assess the need for upgraded equipment in the major fields of academic science and engineering. The study involves a representative sample of 43 major R&D universities and 24 medical schools. In addition to this project, Dr. Gee outlined an interagency study of academic science and engineering laboratory facilities. This study (sponsored by NIH, NSF, the Department of Defense and the Department of Energy) is designed to assess the condition of university research facilities and determine the needs for remodeling or new construction.

Mr. Crowley noted that the importance of assisting universities to meet instrumentation needs had become particularly apparent in 1980 when an AAU/NS study revealed that the median age of research equipment in university laboratories was twice that of instruments in industrial or government facilities. Accordingly, the AAU, the National Association of State Universities and Land Grant Colleges, and the Council on Governmental Relations had initiated a project to determine management and planning strategies that would enable universities to more efficiently meet their research equipment needs. The project is supported by a number of government science agencies including the NSF. The project would culminate in regional seminars as well as a Washington briefing to present conclusions and recommendations.

The CAS Board expressed its strong support for these efforts to quantify the equipment and facility needs of academic laboratories. However, the Board emphasized the importance of developing mechanisms that will continue to assess these requirements on a regular basis. There was some concern expressed regarding the source of funds to upgrade facilities and equipment. It was felt that efforts should focus on securing supplemental support so that the necessary funding would not be derived from the direct or indirect costs of research grants.

II. BUSINESS MEETING

A. ACTION ITEMS - CAS Board

1. Approval of Minutes

The minutes of the September 21-22, 1983 CAS Administrative Board meeting were approved as submitted.

2. Appointment of 1984 CAS Nominating Committee

Dr. Hill reviewed the portion of the CAS bylaws relevant to the appointment of the nominating committee. The Board reviewed a list of the representatives and public affairs representatives of member societies.

ACTION: The CAS Board selected six individuals (three basic scientists and three clinical scientists) to serve on the 1984 CAS Nominating Committee under the chairmanship of Dr. Hill.

3. Future Directions of the Council of Academic Societies

Dr. Hill reported that the Council of Teaching Hospitals had developed a document outlining the challenges facing teaching hospitals and the COTH as a constituent part of the AAMC. The AAMC Executive Committee had agreed that the CAS and COD Administrative Boards should consider the possibility of similar efforts from the perspective of faculty and deans, respectively. The Board agreed that a white paper outlining the future directions of the CAS would be useful. It was suggested that such a document should highlight the issues and challenges for faculty that had been raised at the April 10-11 CAS Interim Meeting. In addition, the Board concurred that the paper should focus on organizational mechanisms that might improve the ability of CAS to assist member societies and individual faculty members in addressing these challenges.

ACTION: The CAS Board requested staff to develop a draft white paper on the future directions of CAS for review by the Board at its June meeting.

4. Resident Involvement in the AAMC

The Organization of Student Representatives (OSR) had requested that residents be incorporated into the AAMC constituency with an active role in policy-making activities of the Association. The COD Administrative Board had agreed that the involvement of residents is important and had asked the CAS Board to explore options that would achieve an appropriate level of resident participation.

The CAS Board reviewed ways in which residents have had an opportunity to participate in the Association's activities. The primary vehicle had been invitational conferences with residents on subjects related to graduate medical education. In addition, the Board discussed whether existing organizational structures within the AAMC would effectively accommodate resident involvement as well as the costs associated with such an expansion of activities.

Pamelyn Close, OSR chairperson, joined the CAS Board to present the views of the OSR regarding this issue. She stated that the OSR hoped that the other administrative boards would be supportive of efforts to involve housestaff in AAMC activities in a more defined manner. The CAS Board expressed their sensitivity to the issue of resident involvement in AAMC. However, it was noted that the request for expansion of their involvement in the Association (beyond the

invitational conferences) had not been initiated by residents themselves.

ACTION: The CAS Board agreed that the establishment of a new organizational structure or modification of an existing structure for the purpose of expanding housestaff involvement in the AAMC would be inappropriate at this time. The Board agreed that resident participation in AAMC activities should continue to be facilitated through mechanisms such as invitational conferences.

B. ACTION ITEMS - Executive Council

1. New Challenges for the COTH and the Department of Teaching Hospitals

Dr. Richard Knapp of the AAMC staff reported that the COTH had prepared a document outlining the challenges facing teaching hospitals and ways in which these challenges might be addressed by the Department of Teaching Hospitals of the AAMC and the COTH membership. Dr. Knapp noted that among other issues, the paper examines the criteria for COTH membership in detail, noting the importance of recognizing the diversity of teaching hospitals. He stated that the document represents a first step in identifying the challenges that will require careful consideration and action in coming years. The CAS Board was asked to approve the dissemination of the document for review and comment.

ACTION: The CAS Board voted to approve the dissemination of the document, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" for review and comment.

2. American Council on Transplantation

Dr. Swanson reported that the AAMC had been asked to join the American Council on Transplantation. Although the Association generally has taken a conservative approach to membership in other organizations, it had been suggested that an exception might be made in this case, in view of the heightened awareness regarding this issue, the important goals of the organization, and their relevance to the AAMC constituency. The CAS Board agreed that the goals of the organization were quite important; however, the Board deferred action on a decision to join the ACT until more could be learned about its activities.

3. Autonomy of Specialty Certifying Boards

Dr. August Swanson discussed the autonomous control that specialty boards have over their policies regarding eligibility requirements for certification. If a change in training requirements necessitates an amendment to the special accreditation requirements for a given specialty, it must be approved by the Accreditation Council for Graduate Medical Education. Otherwise, policy changes may be made by each board without review or approval by any other agency. The American Board of Medical Specialties (ABMS) must simply be notified of planned changes in the requirements 180 days prior to implementation.

The CAS Board was asked to consider the merits of this autonomous arrangement. It was pointed out that it is the hospitals and medical schools which must cover the additional costs incurred by an extension of training time, as mandated by the pathology board. It was agreed that particularly at a time of shrinking resources for the support of graduate medical education, changes in training requirements or other specialty board policies that affect the programs and institutions themselves should be open to discussion by the ABMS.

ACTION: The CAS Board agreed to recommend that the AAMC submit a formal request that the ABMS bylaws be amended to require member boards to submit all changes in training requirements to the ABMS for approval.

C. DISCUSSION ITEMS - CAS Board

1. 1984 CAS Fall Meeting

Dr. Hill reviewed the overall plans for the AAMC Annual Meeting. The theme will be "Medical Education in a Changing Environment." The CAS is scheduled to meet on Sunday, October 28 and Monday, October 29 during the annual meeting. The Monday session will include the annual business meeting. The Board was asked to consider topics and speakers for the Sunday afternoon program. It was agreed that the session should focus on the white paper regarding the future directions of the CAS (see page 3). In addition, the Board agreed that special attention should be given to the report of the GPEP panel.

D. DISCUSSION ITEMS - Executive Council

1. Legislative Update

Dr. Thomas Kennedy provided a brief update on current legislative activity including the NIH renewal legislation, the FY 1985 budget, and organ transplantation legislation. Dr. Kennedy noted that the pace on Capitol Hill was frenetic because of the shortened session (due to convention and election recesses) and the looming budget deficits.

Dr. Kennedy also reported on the establishment of an independent Government-University-Industry Research Roundtable under the aegis of the National Academy of Sciences.

III. ADJOURNMENT

The CAS Administrative Board adjourned at 12:30 p.m. The next meeting will be held on June 27-28.

MINUTES
NOMINATING COMMITTEE
COUNCIL OF ACADEMIC SOCIETIES

May 16, 1984

PRESENT:

Committee Members

Robert L. Hill, Ph.D.
Chairman, Presiding
Joe Dan Coulter, Ph.D.
Lewis Aronow, Ph.D.
Gordon Kaye, Ph.D.
Virginia V. Weldon, M.D.
S. Craighead Alexander, M.D.
Benson R. Wilcox, M.D.

Staff

August Swanson, M.D.
Elizabeth Short, M.D.
Carolyn Demorest

The CAS Nominating Committee met by conference call on May 16, 1984 to select the slate of nominees to be presented at the Fall CAS business meeting. Prior to the conference call, background materials had been circulated for review by the members.

As a result of the customary rotation of Board members, one basic science position and two clinical science society positions will become vacant and the Chairman-Elect position is to be filled by a basic scientist.

Potential nominees were chosen from among the official Representatives and Public Affairs Representatives of the 76 member societies. They were nominated on the basis of their stature as well as past experience in CAS/AAMC activities. In addition, the Committee strove to maintain a broad representation of disciplines on the Board.

The slate developed was as follows:

CHAIRMAN-ELECT

David H. Cohen, M.D., Society for Neuroscience, Stony Brook, L.I., New York

BASIC SCIENCES

For a three year term:

Douglas Kelly, Ph.D., Association of Anatomy Chairmen, Los Angeles, California

CLINICAL SCIENCES

For three year terms:

A. Everette James, Jr., M.D., Association of University Radiologists, Society of Chairmen of Academic Radiology Departments, Nashville, Tennessee

Frank M. Yatsu, M.D., American Neurological Association, Houston, Texas

All of the nominees have agreed to serve if the nomination is ratified by the Council at the Annual Meeting.

As its final order of business, the CAS Nominating Committee recommended that Dr. Virginia V. Weldon, Chairman-Elect of the Council of Academic Societies, be nominated for Chairman-Elect of the AAMC Assembly.

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Lynn Morrison

NAME OF SOCIETY: University Association for Emergency Medicine

MAILING ADDRESS: 900 West Ottawa, Lansing, MI 48915

PURPOSE: To improve the quality of medical care of the acutely ill and injured by operating as a scientific and educational organization.

MEMBERSHIP CRITERIA: See UA/EM Constitution, Article III, Sections 1, 2, 3, and 4.

NUMBER OF MEMBERS: 638 at September 20, 1983

NUMBER OF FACULTY MEMBERS: 407

DATE ORGANIZED: November 30, 1971

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

June 3, 1983 1. Constitution & Bylaws

June 1-4, 1983 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

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

X YES _____ NO

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

501 (c) (3)

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

X a. Approved by IRS

___ b. Denied by IRS

___ c. Pending IRS determination

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

Mary Ann Schropp
(Completed by - please sign)

September 20, 1983
(Date)

UNIVERSITY OF SOUTHERN CALIFORNIA, SCHOOL OF MEDICINE, LOS ANGELES, CALIFORNIA 90033
DEPARTMENT OF ANATOMY AND CELL BIOLOGY
1333 SAN PABLO STREET
(213) 224-7277

June 4, 1984

Elizabeth M. Short, M.D.
Association of American Medical
Colleges
Suite 200
1 Dupont Circle, N.W.
Washington, D.C. 20036

Dear Libby:

I am writing in response to your request of May 1, 1984, that I review the application of the University Association for Emergency Medicine for membership in the Council of Academic Societies. I am sorry to have taken so long to complete this task.

I have now reviewed the materials which you sent, and as a result I should like to recommend that this association be admitted to membership.

It is clear that the University Association for Emergency Medicine has been constituted to pursue a mixture of educational, scientific, and clinical management goals. The group enjoys a relatively large and apparently growing membership. Well over 90% of the membership hold M.D. degrees with a significant sprinkling of doctors of osteopathy, a few nurses, and a few Ph.D.s. Two-thirds of the membership hold faculty positions in schools of medicine or their equivalence. The association holds regular annual meetings, manages a relatively large and diverse budget related to the many active projects the group has undertaken. The majority of the scientific sessions at the annual meetings appear related to emergency management and methodology and trends in the type of emergencies that present. Additional topics include developmental trends in the roles of emergency medical centers.

I conclude that while there will be a fair amount of overlap in the interests of the membership of the University Association for Emergency Medicine with those of other clinical associations, the group represents an important and viable educationally oriented force which is an important part of each of our medical centers. I believe the association is well qualified for membership in the Council of Academic Societies.

Sincerely,

Douglas E. Kelly, Ph.D.
Professor and Chairman
Department of Anatomy and Cell Biology

DEK:dm

The University of Texas
Health Science Center at Houston

MEDICAL SCHOOL
Department of Surgery
Frank G. Moody, M.D.
Professor and Chairman
Surgeon-In-Chief Hermann Hospital

6431 Fannin, Suite 4.020
Texas Medical Center
Houston, Texas 77030
(713) 792-5400
797-2990

May 30, 1984

Elizabeth M. Short, M.D.
AAMC
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Libby:

I looked through the University Association for Emergency Medicine packet and it seems like they properly qualify for representation on the Council of Academic Societies. If there is some type of technical problem, please advise me. Otherwise, I will recommend this to the CAS.

With all best wishes for an enjoyable Summer.

Sincerely,

Frank

Frank G. Moody, M.D.

FGM/mka

DISTINGUISHED SERVICE MEMBERSHIP NOMINATIONS

In June, 1980 the CAS Administrative Board established the policy that an individual would automatically be considered for nomination to the category of distinguished service membership in the AAMC if he/she had served as chairman of the CAS, chairman of the AAMC representing the CAS, or as a member of the CAS Board for two consecutive terms. Accordingly, the CAS Board should consider the following individuals:

David M. Brown	CAS Chairman, 1981-82
Frank C. Wilson	CAS Chairman, 1982-83

As background for the discussion, the sections of the AAMC bylaws pertaining to distinguished service membership and the current list of distinguished service members from CAS are shown below.

AAMC Bylaws

- Section 2B - "Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who have made major contributions to the Association and its programs."

- Section 3E - "Distinguished Service Members shall be recommended to the Executive Committee by either the Council of Deans, the Council of Academic Societies, or the Council of Teaching Hospitals. The Executive Committee shall present Distinguished Service Member nominations to the Executive Council."

CAS Distinguished Service Members

Robert M. Berne
F. Marian Bishop
A. Jay Bollet
Samuel L. Clark, Jr.
Carmine D. Clemente
Jack W. Cole
Ludwig W. Eichna
Ronald W. Estabrook
Harry A. Feldman
Patrick J. Fitzgerald
Robert E. Forster, II
Daniel X. Freedman
Rolla B. Hill, Jr.
John I. Nurnberger
Thomas K. Oliver
Hiram C. Polk
Jonathan E. Rhoads
James V. Warren
Ralph J. Wedgwood
William B. Weil, Jr.

DRAFT

COUNCIL OF ACADEMIC SOCIETIES

ISSUES FACING THE FACULTIES

The Council of Academic Societies was formed in 1966 as the mechanism for faculty representation in the governance of the AAMC. At the first meeting it was resolved that "...the Council should address itself to problems that were general enough to concern many, no 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 challenge of identifying such issues for debate and action has continued unabated since, with policies formulated and national consensus developed on a wide range of issues in medical education, research and patient care. But there is no surcease; the challenges facing the medical schools today are as great as they have ever been.

Thus, as we approach the 20th year of the tripartite organization of the AAMC, a concensus emerged that it would be worthwhile for each of the three Councils to review its organization, membership and activities and to undertake a long-range effort to identify those issues which from its perspective represented the major challenges of the next five years.

The Council of Academic Societies devoted its Spring meeting to the identification of some of these issues and this paper continues that effort to delineate the challenges and suggest the role of the CAS and the AAMC in helping to meet them.

Despite dramatic changes in the environment of the medical school, the three traditional missions of the faculty collectively remain unchanged. These are the education of predoctoral and postdoctoral students and professionals in medicine and the medical sciences, the generation of new knowledge and insights in the biomedical and behavioral sciences and the provision of the highest quality patient care in our academic medical centers.

Challenges in Education

Background

Medical school faculties are responsible for the education and training of over 140,000 students in medicine and the biomedical sciences (Table 1).

Table 1

Medical Students	66,484
Residents	50,381
Graduate Students in Basic Science	16,701
Clinical Fellows	7,133
Total	140,689

There is great variation in the student mix among institutions. At one institution the combined total of graduate students and residents is 2.6 times greater than the number of medical students. At another, the number of medical students is greater by a factor of 2.7.

The diversity in numbers and types of students among academic medical institutions reflects the variation among them in their degree of concentration on the three major missions common to all--education, research and service. However, every medical school faculty member would concede that education is the singular mission that characterizes academic medicine. Biomedical research is done in organizations other than medical schools and medical services are principally provided by

non-academic physicians and hospitals. The education of young men and women who will be future practicing physicians, clinical investigators and biomedical scientists in a responsibility unique to the academy. It follows that a principal concern of the Council of Academic Societies should be the continual improvement of biomedical education.

During the past three decades the educational responsi- bilities of medical school faculties have grown and become more complex. Neither the growth in size and mix of the student body nor the complexity of what must be taught and learned has been accompanied by significant changes in educational philosophy or methods. While the research techniques of the 1940s have been almost completely supplanted by ever more sophisticated and sensitive methods, students are still expected to learn by being told what the faculties know and by generally unstructured, hands-on experiences.

As the amount of information to be transmitted has increased and technology has become more complicated, this educational strategy has become obsolete. However, the principal change for coping with this educational challenge has been to increase the time students spend in their program. Although medical school remains a four year program, the number of weeks of required attendance has increased. Residency programs are being lengthened as is postdoctoral training for basic scientists. It seems apparent that there must be a practical limit to this strategy.

The Issues

The commitment to education by most medical school faculty members is influenced by how much this responsibility interdigitates with their research and service activities. Residents and clinical fellows who

assist in patient care, and research and graduate and postdoctoral students who collaborate with faculty members in research, are afforded commensurately more personal time and attention. Contact with medical students is considered important, but most faculty members try to confine their contribution to medical student education to simply transmitting their specialized store of information to them. There is a universal perception that educational activities that do not contribute to, or detract from, productivity in research or patient care are likely to hinder recognition and advancement. Engagement with education is thus the third priority for most of our faculties.

The increase in the number of students of all categories, although paralleled by an even greater increase in the number of faculty members, has diminished the personal relationship between students and faculty. This holds true not only for medical students whose number has doubled in the past two decades but also for graduate students, residents and fellows. In many institutions chairmen and senior faculty do not have sufficient time to get to know the cadre of students for whom they have ultimate responsibility.

In the foreseeable future it is unlikely that faculties' involvement in research and patient care will change. Indeed these missions are apt to make greater demands on the energy and time that is available. It is also unlikely that the number of students will decrease significantly and the mix may become more complex as specialization increases in both basic science and clinical disciplines. If the education of all students for whom faculties have responsibility is to be improved, a multifaceted approach that involves

restructuring the organization and methods for accomplishing the educational mission of medical school faculties must be undertaken.

Strategies

I. Accreditation, Licensing and Specialty Certification

In the United States the faculties of institutions of higher education are privileged to determine the content of students' education and the methods of their instruction within broad guidelines set forth by accrediting agencies. For medical school faculties these agencies include the Liaison Committee for Medical Education for medical student education, the Accreditation Council for Graduate Medical Education for resident education, and regional accrediting agencies for education programs for graduate students in the basic sciences. To a significant degree the faculties' decisions about educational programs for medical students and residents are also influenced by professional licensing policies in the states, national licensing examinations used by states and the policies and examinations of medical specialty certifying boards.

Thus, while faculties have the ultimate responsibility for accomplishing the educational mission of their institutions, there are practical limits to educational experimentation that are imposed by external authorities. The degree to which these tend to perpetuate conventional educational approaches and inhibit improving the education of the students for which medical school faculties are responsible should be a concern of the Council of Academic Societies.

- Are CAS representatives and their societies sufficiently knowledgeable about the policies of accrediting, licensing and certifying agencies?

- Are there specific policies at present in force that need to be altered if the education of all types of students for which medical school faculties are responsible is to be improved?
- Should the AAMC/CAS develop a program to increase the level of knowledge and involvement of academic societies in the assessment and modification of accrediting, licensing and certifying policies?

II. Specialization and Fragmentation

Specialization in both basic and clinical sciences is increasing with the growth of knowledge and the complexity of research, diagnostic and therapeutic technologies. Specialization inevitably leads to fragmentation as individuals with common interests draw together to share their experience and accomplish a common goal. At the national level this is evident in an increasing number of societies and associations and at the institutional level in multiple administrative units. This fragmentation can result in faculty members and students in one discipline or specialty neither understanding nor appreciating the contributions that other disciplines and specialties might make to the education of their students.

- Is fragmentation in the biomedical sciences impairing students' education?
- Should the CAS provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences?

III. Intrainstitutional Competition

Within the institutions there are competitive pressures among specialties that may or may not accrue to the benefit of students' education. Some examples of these are:

a. Departments and divisions competing for an increased share of time in medical students' curricula in order to expose students to a discipline or specialty in hopes of recruiting them, or to enhance their f.t.e. faculty involvement with medical student education.

b. Clinical departments and divisions competing for bed space or for preferential control of procedures and facilities to enhance their service and/or research capabilities or to enlarge their educational programs for residents and fellows.

c. Basic science departments competing for research and teaching space to augment their research and graduate student education programs.

- Do these competitive pressures significantly detract from an institution's ability to meet its educational obligations to <u>all</u> of its students?
- Are there activities that the member societies of CAS could carry out in concert to reduce any negative effects on education of intrainstitutional competition among administrative units?

IV. National Competition Among Disciplines and Specialties

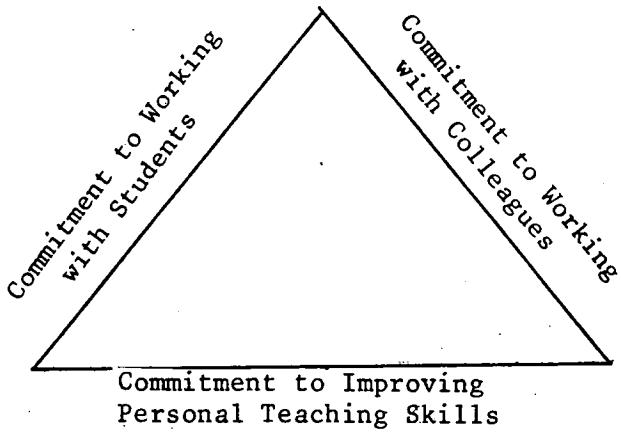
At the national level, especially among clinical disciplines and specialties, there is competition for recognition and for students. This is evidenced by the proliferation of specialty certifying boards

and subcertification of special competence by established boards. Competition for students has caused opthalmology, neurosurgery, otolaryngology and neurology to develop a separate matching program that selects medical students early in their senior year for entry into their residency programs in their second postgraduate year.

- Should AAMC/CAS play a more vigorous role in debates about the creation and recognition of new specialties and subspecialties?
- Should the AAMC/CAS take steps to minimize the effect on students' education of the competition by various disciplines and specialties to recruit them?

V. Enhancing Faculty Commitment to Education

Ultimately, improving education will depend upon the depth of commitment that individual faculty members are willing to make to this mission. This commitment has three components:



a. Commitment to Improving Personal Teaching Skills

The General Professional Education of the Physician Project has identified the importance of focusing on the personal development of each student. To make the student the focus of education will require that faculty members have the ability to work with that students and

will require that students assume personal responsibility for their own education. Most faculty members now consider their educational role to be to inform students about their specialized area of expertise. Working with students who expect to be active learners rather than passive recipients of information is a role that many faculty members are not now prepared to assume.

- Should the educational commitment of faculty members extend to a commitment on their part to improve their own personal teaching skills?
- Should the AAMC/CAS develop a national program to assist individual faculty members to improve their teaching skills?

b. Commitment to Working with Students

The level of individual faculty members' commitment to working with students depends upon their perceptions of institutional priorities. These priorities are signified by the interests and actions of deans and department chairmen and may imply that involvement with students is valued or not valued. CAS members include societies or chairmen for essentially every discipline and specialty in academic medicine.

- Should the AAMC/CAS develop programs to heighten the willingness of chairmen to enhance the commitment of the faculty members of their department to working with students? What might be the thrust of such programs?

c. Commitment to Working with Colleagues

The planning and implementation of improved educational programs for all types of students will require both intra- and interdisciplinary discussions and debates. Deans, chairmen and faculty members must be willing to commit to the time and energy necessary to work with their colleagues to accomplish and perpetuate continual improvement. Such a commitment is likely to impinge upon the time and intellectual resources devoted to other institutional or personal missions.

- Should the AAMC/CAS undertake to increase the commitment of chairmen and faculty members to planning and implementing improvements in biomedical education? If so, how?

Challenges in Research

Background

The past 20 years have witnessed an unparalleled explosion in our knowledge and understanding of fundamental processes in the biological sciences. Indeed, this can be characterized as the golden age of biology. The fruits of these discoveries, ever more readily applied to solving problems of human health and biomedical research, have contributed to improved survival and better quality of life for people afflicted with a broad range of diseases. Despite this opportunity there has been a slowing of growth in research funding. Federal research support to our medical schools in constant dollars grew through the early 1970s but has declined an annual average 4.4 percent over the last five years. Between 1961 and 1981, these funds declined from 31% to 22% of total financial support of medical schools. In constant dollars, federal support for research training through the

NRSA Program declined from $159 million in FY 72 to the 1972 equalivant of $76 million in FY 83. While the number of individual investigator (R01) NIH grantees has been over 12,000 for the past five years, the percent of new P.I.s has been falling steadily. The 8.3% new grantees in 1982 was the lowest percentage since 1970. The number of clinical (M.D.) investigators also continues to decline from 32% of the new principal investigators in 1968 to 15% in 1982.

The Issues

Faculty members see the availability of research funds as the most urgent challenge to continuing their research mission. They want to identify effective ways to communicate to Congress the importance of an investment in basic research as vital to future progress in improving health and as substantively different from day to day expenditures on health care. They do not see any other sector of the economy as a major source of funds for such research, although they do see university-industry relationships as of importance in a limited and targeted number of areas.

Experience with this no growth era in research funding has led to concerns in a variety of areas. There is a desire to achieve an appropriate balance between funds devoted to disease-specific research and those devoted to interdisciplinary or more basic research; between funds expended on "safe" versus innovative or high risk research; between funds expended for investigator- initiated research versus other vehicles for funding; and between funds to support the direct versus the indirect costs of research.

There is concern that under increasing fiscal pressures the peer review process is becoming eroded or politicized, and that the peer

review process engenders a sense of futility in reviewers and applicants alike when so much meritorious research cannot be funded. Discussion has arisen about the feasibility or desirability of identifying the most promising areas of research and establishing priorities for the next five years across disciplines.

There is concern that an attempt to even out arbitrary year-to-year fluctuations in the number of grants awarded has been twisted into an inflexible mandate that 5,000 grants must be funded yearly, regardless of whether this represents too high or low a proportion of the NIH budget, and regardless of the actual number of meritorious research proposals submitted. Some means must be found to explain the desirability of long term stability in research funding and the opportunities for creative research which cannot be funded with the present budget limitations, while avoiding reliance on a single number or percent of grants. NIH must retain the flexibility to make funding decisions based on research opportunity and scientific merit.

Attracting the best minds to research and providing proper support of research training and early faculty development are high priority issues for faculty. There remains serious concern that the increased competition for limited research funds makes a career in research seem less attractive to young people and that high indebtness of medical students will serve as a further disincentive to consideration of a faculty career. While there is enthusiasm for new training programs such as the Physician Scientist Awards, faculty are aware that, especially in training clinical investigators, there is need for institutional training grants which can provide entree for those with no prior research experience. There is concern that policymakers must

appreciate that such training programs will have a lower yield of career researchers than those which select fellows with previous research experience. In the present job market placing young trainees in faculty positions and providing adequate support during the startup years has become more crucial and faculty realize that special effort needs to be devoted to ensuring a continuous flow of young, talented people into the academic ranks. Support may also be needed for mid-career faculty to enable them to update research skills and remain competitive in a era of increasingly sophisticated research technology.

It seems doubly difficult that an environment already fiscally restricted should face increasing regulation as well, but specific directives are in effect or pending in regard to disposal of chemical and low level nuclear waste, to release of genetically engineered organisms in field trials, and in regard to the use of animals in research. The latter threat is particularly acute since there is a growing and determined movement in this country to restrict or prohibit the use of laboratory animals through both national and local legislation and regulation. Determined efforts are needed to restrict burdensome and unnecessary regulation and to make clear the toll such regulation exacts in inhibiting the flow of scientific discovery.

Concern is mounting about the inadequacy or obsolescence of research facilities and equipment. Restriction of funds for construction or renovation and for larger scale equipment purchase have taken their toll and efforts underway to assess the needs of the research universities and to seek sources of funding are timely.

Strategies

I. Efforts to improve the funding for biomedical and behavioral research and specifically to support the programs of the NIH have been an urgent priority of AAMC/CAS and it is clear that this emphasis and effort should continue. The pressures of the present economic climate mandate that AAMC continue a strong advocacy role for the benefits of basic and clinical research, and speak to the urgent need for a continued investment in research when the primary concern of Congress and DHSS has shifted to cost containment and limitation of government expenditures in health care. The Council in its recent discussions recognized the need for concerted action across all academic disciplines and specialty interests and supported the concept that societies should seek broad-based increases in research funding rather than specific and restricted appropriations.

- Should AAMC/CAS continue and expand advocacy for research appropriations?

  Recent AAMC efforts to articulate general Principles for the Support of Medical Research and to provide vigorous leadership of an Ad Hoc Group on Medical Research Funding, which has in each of the last several years successfully produced a unified request for increased NIH/ADAMHA appropriations to which over 140 societies were signatories, are examples of such efforts.

- Should CAS societies increase their individual advocacy of research support?

Individual societies can play key roles in educating the public, the media and Congress concerning the importance and benefits of research and the national need for broad-based, stable research support. Individual societies have provided speakers bureaus, science writers conferences, extended meetings with key Congressional staff and special sessions at their science meetings. Should CAS provide a forum for societies to share their experiences, successes and failures at these efforts?

- Should AAMC/CAS provide a forum for discussion and development of policies to balance competing interests in an atmosphere of constrained funding?

As a forum for a diversity of faculty viewpoints the CAS might provide a valuable consensus view on Congressional or NIH/ADAMHA priorities within limited funding scenarios. Should policy on allocation of funds to types of programs (e.g., investigator- initiated vs. center grants) or types of research become a focus for CAS concern?

- Should specific effort be devoted to concerns expressed for the deteriorating condition of research facilities/equipment? If so, how?

II. Research training and faculty development are important priorities for academic societies. What strategies will be useful to ensure continued support of an optimal educational milieu for the training of future medical research personnel?

- Should AAMC/CAS continue, as high priority, efforts to achieve increased funding for research training?
- Should AAMC/CAS become involved in an examination of the strengths and weaknesses of the present national research training effort and debate such issues as balance between different types of training (MSTP, fellowships, institutional training grants), trainee stipend levels, and appropriate length and methods of training?
- Is there a role for AAMC/CAS in generating initiatives for support of junior faculty/new investigators? Should CAS focus efforts on faculty development and advocate such policies as loan forgiveness for academic careers or measures to assure a better success rate for first time grant applicants?
- What roles do individual societies play in faculty development within their own disciplines? What more could be done in this regard? Is there a coordinating role for CAS?

III. Research is best conducted in a milieu which has appropriate safeguards for health, environmental quality and humane treatment of research subjects from human to invertebrate. However, excess regulation, burdensome paperwork and attempts to interdict whole areas of research must be resisted.

- Should AAMC/CAS and individual academic societies involve themselves wholeheartedly in efforts to limit restrictions on the use of animals in research?

AAMC, in conjunction with the AMA and American Physiological Society, has recently assumed a leadership role in building a coalition of concerned societies and coordinating their efforts to this area. Should CAS become more active in identifying roles which scientists and societies can play in this regard? If so, how?

Challenges in Patient Care

Background

The patient care environment of our medical schools has changed dramatically in the past twenty years and it appears clear that we are on the verge of a new set of sweeping changes. Since the early 1960s academic medical centers have grown in size and complexity; they have expanded their high technology and tertiary care capabilities and serve as regional and in some cases national referral resources. They have continued their traditional role in service to the medically indigent but they also acquired new patients and new sources of income with the advent of medicare/medicaid. Medical service income has expanded from 6% to 30% of the annual income of the medical schools. Full-time faculty in the clinical disciplines have grown from 7,200 in 1961 to 40,148 in 1982. Many faculty are increasingly engaged in fund-generating clinical activities and faculty practice plans have emerged as a management system for faculty effort devoted to reimbursable patient care. Faculty members have been part of a philosophic effort to bring high quality health care to all Americans and have accomplished this by expanded patient care efforts in the medical center, outreach and community programs and education of a larger yearly cohort of new physicians for the nation.

Now, the rapid growth of health care expenditures as a proportion of GNP has shifted the philosophic emphasis from providing universal access to quality care to providing cost-efficient care. Those paying for medical care have rapidly induced a shift to cost containment strategies such as HMOs, preferred provider plans and prospective payment by diagnosis rather than cost reimbursement. For-profit concerns are becoming increasingly involved in the "business" of medical care delivery.

Challenges

From the perspective of the faculties the overriding priority is to assure that patients receive scientifically based, high quality care. There is great concern to be sure that strategies to control costs do not have an adverse impact on the ability to deliver quality care. Faculty members are sensitive to the difficulty in developing quantifiable, objective measures of quality care once one begins to compare outcomes more subtle than survival rates. But they are also best positioned as the leaders in research and innovation in care to establish the norms and protocols by which care by all providers should be judged. The academic community can also encourage the development of pricing and reimbursement systems which value cognitive skills as well as procedures.

There is concern about how successfully the academic medical center, by its very nature, can adapt to a competitive environment. Faculties have multiple missions and traditionally, generating a profit, or even staying out of the red, has not been one of them. Patient care activities have been viewed in the context of the types and number of patients needed to provide a balanced educational

program, the spectrum of cases necessary to meet particular clinical research needs/interests of faculty groups, and the uniquely challanging diagnostic and management dilemmas whose referral and successful care marked the medical center as an academic resource. Additionally, the charitable obligations, especially of the large urban public hospitals, have loomed large. The emphasis has been much more on inpatient care than on long term, primarily ambulatory care. While there has been growing dedication in the last decade to recovering all reimbursable costs for faculty efforts in patient care, programmatic decisions have traditionally not been based on patient revenues.

Faculties are concerned that attempts to position the academic medical center, or any of its individual hospitals and clinics, in a more fiscally competitive position include full consideration of the resources necessary to the teaching, research, and more traditional patient care missions. They are concerned that faculty members have an opportunity to understand the economic issues and participate in formulating policies related to patient care and resource allocation especially for scarce, high technology resources. There is general recognition that some economies can be realized by better management of hospitals, but concern that costs are ultimately not as controllable in teaching as in non-teaching settings. It is important that policy decisions affecting patient care not be made under the guise of management efficiency without due deliberation and consultation with the medical staff.

Pressures appear to be building towards the development of multispecialty group practices of faculty designed to provide competitive primary care so as to ensure a steady source of patients

for the academic center. There is concern for how academic centers with strong inpatient and referral emphasis can reorient themselves and continue to maintain a balanced commitment to education and research. Decisions will have to be made about the balance between primary care and subspecialty faculty which such an orientation may require, and the balance between faculty primarily devoted to patient care and those primarily engaged in research. Equitable promotion and tenure policies will need to be developed that accommodate faculty predominantly engaged in only one of the three traditional roles, to ensure a mutually supportive and multidimensional faculty.

Issues related to medical education remain a high priority. The faculty time, patient time and physical resources necessary to run a good clinical teaching program seem at odds with a streamlined, efficient and cost cutting approach to care. While we must teach cost conscious practice to students, the teaching process, as distinct from the outcome, is time and resource intensive.

Challenges to graduate medical education are also emerging. Government and third party payors are increasingly reluctant to allow for house staff stipends and the increased patient care costs of the teaching setting. The traditional support of this large component of physician education and of patient care seems to be eroding and there is no readily identifiable alternate source of revenue.

Faculties also anticipate the possibility that the combinations of pressures to limit payment for graduate medical education and the predicted surplus of physicians may lead to increasing efforts to curtain or alter the specialty distribution of physicians in training.

Strategies

I. A high priority of the faculties is to insure a continued emphasis on quality in the context of, and if necessary in contradistinction to economical health care.

- Should AAMC/CAS continue to emphasize, in all appropriate contexts, the concern of academic medical centers and their faculties for quality of health care?
- Can individual societies play a role in determining or promulgating norms or standards for quality patient care within their disciplines? How?

II. Attempts to make the academic medical center more fiscally competitive or promote marketable services must be made with full awareness of the impact of these policies on the education, research and traditional patient care missions of the faculty, and with the active participation of faculty in establishing such policies and resource allocations.

- What role can CAS play in facilitating cooperation between faculties, deans and hospital executives in formulating policies related to patient care?
- Should CAS play a role in bringing together faculty members active in governance of their institution's practice plans to exchange ideas and address shared concerns?
- Should AAMC continue its efforts to gather and disseminate information on different organizational models for faculty practice plans?

- How can faculties and academic societies participate in scarce resource allocation decisions?

III. Faculties must position themselves to maintain their prerogatives as the ultimate decision makers in the diagnostic evaluation and management of patients. A century of efforts to pull medical decision making onto a scientific base must not be undone and an economic base substituted.

- Should AAMC/CAS begin to explore its position in relation to proposed plans for future third party reimbursement of physicians?

IV. If a large scale group practice providing patient care services across the primary-to-tertiary and ambulatory-to-ICU spectra is a future model for faculty efforts in patient care, can CAS, which represents these spectra within its membership, provide any collective assistance to its members or to medical schools in this arena? If so, what and how?

- Are CAS societies interested in dealing with issues of promotion, tenure and multiple faculty tracks?

V. Concern for medical education conducted in the context of patient care remains a high priority for faculty. Efforts are necessary to assure the proper sites, facilities and types of patients necessary for their graduated teaching tasks from beginning medical students through research fellows. Threats to financial support of graduate medical education are emerging and are most germane to the clinical faculty in their disciplinary roles.

- Does CAS support the establishment of an AAMC-wide planning session and Task Force on the future of graduate medical education?
- As a sequel to the Report of the Panel on the General Professional Education of the Physician, should AAMC pursue efforts to define the settings and resources necessary for each stage in the education of a physician?
- Should AAMC/CAS encourage individual academic societies to undertake efforts to examine the resources and manpower necessary for clinical training in their disciplines?

FUTURE DIRECTIONS FOR THE COUNCIL OF ACADEMIC SOCIETIES

Background

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.

"We recommend the information of a Council of 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 Excutive 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 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."

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."

At the second meeting in October 1968, the first CAS chairman, Thomas Kinney, Professor and Chairman of Pathology at Duke, 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."

In 1969 John Cooper became President and completed the move of 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, immediately past President of the AFCR, as its first Director. That office has been the central focus of the CAS, and the plateauing and downturn of federal support for biomedical research and the reduction of research training opportunities have become major continuing concerns of the Council. Other national policy issues have included the clinical laboratory improvement act, medicare

reimbursement of physicians in a teaching setting, ethical standards in research, 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.

Member Societies

There has been no attempt to seek the membership of academic societies in CAS; however, membership has grown steadily and in 1984, 76 societies are represented. Table II displays the current representation of academic disciplines in CAS and Table III the membership by society. It is clear that all of the major medical academic disciplines are represented to some degree although there are no formal "disciplinary chairs" on the Council, and some disciplines are represented by a number of societies.

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. While CAS societies appoint representatives to participate in the business of the Council, the professional interests and responsibilities of these representatives are often 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

Table II

Disciplinary Affiliation of Societies in CAS

DISCIPLINE	Chairman's Group	Research Society	Education Society	General Society
BASIC SCIENCES				
Anatomy/Cell Biology	1	2		
Behavioral Science			1	
Biochemistry	1	1		
Genetics		1		
Microbiology	1			
Neuroscience		1		
Pathology	1			1
Pharmacology	1	3		
Physiology	1	1		
Preventive Medicine			1	
CLINICAL SCIENCES				
Allergy				1
Anesthesiology	1	1		
Critical Care				1
Dermatology	1			
Emergency Medicine			1	
Family Medicine	1		1	
Internal Medicine	1	7	1	1
Neurology	1	2		1
Obstetrics-Gynecology	1	1		1
Pediatrics	1	2		
Physical Medicine/Rehab	1			1
Psychiatry	1	1	2	1
Radiology	1	1		
Surgery				
General	1	4		1
Neurosurgery	1			
Ophthalmology	1			1
Orthopedics	1			1
Otolaryngology	1	1		
Plastic Surgery		1	1	1
Thoracic Surgery	1			
Urology	1			

Table III: 1983-84 Membership List for the CAS

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 Physiatrists

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

society meetings do not permit most societies to consider items on the CAS agenda in advance of a CAS meeting.

Governance

The entire Council meets biannually. A program is planned which permits in-depth consideration of a topic of major interest to academic faculty, and, at the business meeting, there is an opportunity for discussion of some of the major areas in which AAMC/CAS has taken or is considering action. This forum provides for the expression of diversity of opinion on issues, after which a general sense of the Council is sought to aid the Administrative Board in its deliberations.

The CAS Administrative Board is made up of twelve representatives (6 basic science/6 clinical science) selected from the Council at large, and includes a chairman, chairman-elect and immediate past-chairman. All nominations for these positions are made by a Nominating Committee drawn from the Council at large with no more that 2 to 7 members from the present Board. The Board meets four times a year to deliberate on a wide range of issues affecting the medical schools and academic medical centers and endeavors to provide a faculty perspective. The COD, COTH and OSR Boards meet simultaneously.

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 at Administration 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 of 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.

The position of each Board is taken by its representatives to the Executive Council meeting where AAMC positions are finally developed. The CAS has four representatives on the 23 member Executive Council. The past chairman, chairman and chairman-elect and one other Administrative Board member represent the CAS. The remainder of the Executive Council is composed of four COTH representatives, two OSR representatives, nine COD representatives, a distinguished service member and the officers of the Assembly.

The complexity, multiplicity and diversity of the issues addressed, together with the rapidity with which developments occur on the national scene, has required the growth of a full-time professional staff not otherwise occupied with institutional responsibilities. The AAMC staff has played an increasingly prominent role in identifying issues, and analyzing their implications, proposing responses and

coordinating deliberation by the constituencies. At times when rapid response is required the process has involved only the officers of the Executive Committee and those Board or Council members most directly affected or with possible legislative influence.

Challenges

The difficulty of allowing due deliberation and expression of a diversity of opinion while achieving consensus for rapid action have been a source of concern to each of the Councils; this tension between debate and decision, between rank democracy and representative oligarchy, characterizes the governance of most organizations including our medical centers themselves. CAS members have expressed concerns about representational duties when their societies do not meet frequently nor specifically debate AAMC/CAS issues and about Administrative Board representation of their concerns when the Council only meets biannually. Concerns about representation and delegation of decision-making power are highlighted by the difference between CAS and the other Councils where the medical schools and teaching hospitals are represented, qua institutions, by those with decision-making authority. Others view the organization of the CAS as a system for selecting a representative cross-section of faculty interested and involved in the issues who will then function as a collective faculty body at the national level.

There is concern about the depth of expertise faculty can bring to debate on those issues which they confront briefly two or four times yearly. There is a desire to use meetings as an opportunity for education but also a desire for more active discussion and less time spent in passive information transfer.

CAS members also realize the value inherent in the diversity of their Council. They see Council meetings as one of the few opportunities for interdisciplinary conversation across a variety of issues, and disagreement as valuable, not necessarily divisive. Some have expressed the hope that through this Council societies and faculties could learn to collaborate across disciplines. The lessions learned could be applied to enhance the ability of faculty to collaborate between disciplines and across the basic-to-clinical science spectrum in teaching, to collaborate between disciplines and across the M.D.-Ph.D. spectrum in research and to collaborate between disciplines and across the primary-to-tertiary care spectrum in patient care.

Strategies

I. Communication and cohesiveness are problems in a group which only convenes twice a year.

- Should the entire Council meet more often?
- The Administrative Board meets quarterly; should there be some means of communicating Administrative Board deliberations and decisions to the Council between its meetings?

II. Brief biannual meetings are a limited format for extended discussion or development of sufficient expertise on some issues. Are there any ways in which CAS should change its organization to assist it in meeting the challenges identified in this paper?

- Should there be working groups or Task Forces occasionally established to address specific issues in depth? Should these be AAMC-wide or is there a role for CAS-only groups?

- Should there be any standing committees? Would such a mechanism be flexible enough to handle a wide and rapidly changing variety of issues?
- Should there be caucuses or other subgroupings of the Council to achieve smaller groups with more homogeneous backgrounds (e.g. a basic science caucus)? Would such subdivisions detract from the interdisciplinary and faculty-wide dialogue which is seen as a unique strength of the CAS?

III. New member societies or new representatives from societies find it difficult to arrive in media res.

- Should an orientation program be developed for new representatives?
- Should the Administrative Board assume a greater role in communicating with each society about the role of CAS and the desirability of their participation?

SUMMARY

This issues paper highlights many of the challenges which will face the faculty in fulfilling their traditional missions in research, education and patient care. It proposed strategies for dealing with some of these challenges which the CAS might consider adopting. It discusses the organization of the CAS itself and how it might be best structured to deal substantatively with the issues which most concern it. In this preliminary overview of the challenges there has been little effort to establish priorities among the issues or between the missions of faculty. Nor has there been any consideration of how efforts to take on some of these issues might best be orchestrated

given limited financial and personnel resources for the CAS and the very busy schedules and multiple duties of faculty members.

This draft paper will benefit from comments by Council members on the issues, strategies or mechanisms discussed. The consensus document emerging from this effort of the Council and Administrative Board should articulate a faculty perspective on the challenges facing academic medical centers and the AAMC in the near future. Council members should also give serious consideration to ways in which each member society is addressing those issues highlighted in this white paper which are germane to its mission. The collective efforts of faculty members through their societies will be as necessary to success in meeting these challenges as any efforts of the Council as a whole.

Continued Use of an Alternate Matching Plan by Certain Specialties

The Association has been dedicated to preserving and refining the National Residency Matching Program (NRMP) from the time of its implementation in 1953 to the present. The prime purpose of the Program is to make the transition for medical students from undergraduate to graduate medical education as orderly and free from pressure to make premature decisions as possible.

Generally, the NRMP has served both students and programs very well. However, four specialties have felt compelled to select graduating seniors using an alternate matching system in advance of the NRMP match.

In December 1983 the Executive Committee of the Association met with the national leaders of the ophthalmologists, neurosurgeons, otolaryngologists and neurologists to explore why they have chosen an alternate matching system and to examine use of NRMP, which can now fulfill their technical needs. Subsequent to that meeting, all four specialties have decided to continue using the alternate system. The reasons for this decision appear to be due to their desire to select graduating seniors to enter programs in their specialties in their PGY-2 year prior to the NRMP match. In their view those students who are selected are then able to match for a PGY-1 internship year compatible with their specialty training which is to begin the following year.

Since the NRMP can now match students for PGY-2 and compatible PGY-1 internships in the course of the regular match, this reason does not appear sufficient to justify disruption of the resident selection process by an early match that pressures both students and their advisers to make decisions and provide recommendations prematurely.

Should the CAS recommend to the AAMC actions to achieve universal use of the National Residency Matching Program and elimination of the alternate matching system? Should the CAS Administrative Board prepare a statement for consideration by the COD, COTH and OSR Administrative Boards in September urging that all specialty groups represented in the CAS use and adhere to the rules of the NRMP? Should such a resolution be presented to all three Councils and the OSR at the Annual Meeting in November? Are there other actions to be considered?

CAS ANNUAL MEETING PROGRAM

The Annual Meeting Program for Sunday afternoon, October 28, 1984, will be titled "Consideration of the Report on the General Professional Education of the Physician" and will consist of a 90 minute plenary session with two speakers and a two to two-and-a-half hour period for small group discussion. The speakers will be David D. Alexander, President of Pomona College, who will focus principally on college preparation for medicine, and August G. Swanson, who will review the principal conclusions and recommendations about medical student education.

The report will have been sent to all CAS representatives on September 19. Therefore, those attending will have had an adequate opportunity to consider it in advance. A memorandum announcing the Sunday program will accompany the mailing to CAS representatives and member societies' officers.

Sunday, October 28, 1984

Agenda

1:30 pm - 3:00 pm	Presentation by speakers with questions and comments from the floor
3:00 pm - 5:30 pm	Discussion Groups focusing on four of the conclusions contained in the report: 1) Baccalaureate Education 2) Acquiring Learning Skills 3) Clinical Education 4) Faculty Involvement
5:30 pm - 6:30 pm	Reception

CAS Interim (Spring) Meeting

Recent Board discussion has focused around the possibility that the interim meeting of the CAS might be better attended and more effective if it were held at the same time each year and avoided the hazards of travel in winter weather. The site has also been debated and there have been proposals to move the meeting from the Washington Hilton, possibly to a more retreat-like atmosphere.

The Board should consider at this time fixing the date of the CAS Spring Meeting for Thursday and Friday of the second week in March. This timing would allow final consideration of the Spring Meeting agenda at the January Board meeting. These dates for the next few years would be:

March 14-15, 1985
March 13-14, 1986
March 12-13, 1987

The location of the meeting has also been debated and the following suggestions have emerged: 1) the meeting would be hosted at the school of the CAS chairman; 2) a retreat site would be selected which is salubrious, accessible and private (suggestions?); or 3) the meeting would continue to be held at the Washington Hilton. We should fix the time and, if possible, the site for the 1985 Spring Meeting at this Board meeting.

SURVEY OF FACULTY PRACTICE PLANS

The recent inauguration of the Prospective Payment System together with substantial legislative momentum directed toward modifying the system for reimbursement of physician services has created a significant interest in the academic community in the subject of faculty practice plans. On the one hand, there is concern with the technical aspects of the reimbursement system and the rules governing the nature and extent of compensation. Faculty physicians and business managers wish to assure that the system itself does not disadvantage them and to assure that their own appropriate compliance with the rules permits maximum recovery. On the other hand, there is concern that this new focus on the financial aspects of clinical practice in academic medical centers may be diverting attention from the educational, research and public service missions of the institutions.

The AAMC has conducted studies and surveys of medical practice plans in the past, but has not undertaken a significant initiative in this arena since 1980. The attached questionnaire is intended to provide updated information for the Association and its members and to identify issues for further study.

The questionnaire consists of two parts, the first asks six brief questions which are intended primarily to update previous information and to provide a context for the questions which follow. It will permit the classification of each institution's plan into appropriate categories and will make more meaningful the deans' responses to Part II. The second part of the questionnaire is designed to stimulate the deans to identify for the Association key policy and operational issues with respect to their faculty practice plans, to address the subject of potential or developing conflicts with the academic mission of the institution, and to report on pressure from the faculty to change the form, structure or governance of the plan.

Finally, the questionnaire would provide the Association with an identification of both the practice plan business managers and the chairman of the policy setting board or committee responsible for the plan. This information will permit the Association to engage in appropriate follow-up action that may emerge from the responses to the other questions.

RECOMMENDATION: That the Administrative Boards provide comments and suggestions on the survey instrument.

Part I -- Classification of Practice Plans

1. Please indicate the circumstances which best describe the practice arrangements at your institution.

____ There is no practice plan at the institution.

____ There is a single institutional practice plan with a membership requirement for some or all of the clinical faculty.

____ There are departmental practice plans in some or all clinical departments.

____ There are several plans, some or all of which involve more than one department.

____ Other (please explain).

2. What manner of organization best describes the plan at your institution?

____ The practice plan is an organizational unit of the medical school.

____ The practice plan is a formally independent, non-profit entity, but controlled in effect by the medical school administration.

____ The practice plan is a formally independent, non-profit entity, actually independent of the medical school administration.

____ The practice plan is a collection of non-profit entities, organized by department.

____ The practice plan is an independent, for-profit corporation.

____ The practice plan is a collection of for-profit entities, organized by department.

____ The practice plan is an organizational unit of an affiliated teaching hospital.

____ Other (please explain).

3. What circumstances best describe the nature of individual physician compensation through the medical service plan?

____ Compensation is generally stable from year to year regardless of individual practice plan earnings.

____ Compensation gradually increases/decreases in accordance with a long term trend in individual practice plan earnings.

____ Compensation varies directly according to the current year's individual practice plan earnings.

____ Compensation varies directly according to the previous year's individual practice plan earnings.

4. Is a portion of the practice plan income, other than an institutional service charge, provided to the dean?

____ Yes, with no restrictions on the purposes for which the funds may be used.

____ Yes, with some restrictions on the purposes for which the funds may be used.

____ No.

5. Is a portion of the practice plan net income (after clinical salaries are paid) distributed to the department?

____ Yes, with no restrictions on the purposes for which the funds may be used.

____ Yes, with some restrictions on the purposes for which the funds may be used.

____ No.

6. Is it the practice of your institution or any clinical department within it to include practice earnings in the salary base used to compute fractional income charged to NIH research grants?

____ Yes.

____ No.

Part II -- Deans Opinionnaire

1. Please name the two most significant policy issues confronting your institution with respect to the faculty practice plan(s):

   1.

   2.

2. Please discuss operational issues you are now confronting which you believe would be of interest or significance to your colleagues and the membership of the AAMC:

   1.

   2.

3. Do you perceive a developing conflict with the academic mission of your institution resulting from the operation of the faculty practice plan? Please describe in detail:

4. Are you experiencing pressures from members of the clinical faculty to change the form, structure, or governance of the plan? Please specify and give your view of why the change is being sought.

5. Please provide us the names of the:

   a. Practice Plan Manager -

   _____
   Name

   _____
   Title

   _____
   Telephone number

   b. Chairman of the policy setting board or committee responsible for the direction of the faculty practice plan -

   _____
   Name

   _____
   Title

   _____
   Telephone number

CAS/COD JOINT ADMINISTRATIVE BOARDS MEETING

5:00 p.m., June 27, 1984
Conservatory Room, Washington Hilton

THE USE OF ANIMALS IN RESEARCH

Guests: Charles R. McCarthy, Ph.D.
Director
Office for Protection from Research Risks
NIH

John F. Sherman, Ph.D.
Vice President, AAMC
President, National Society for Medical Research

Discussion will center on:

- the current sociopolitical climate characterized by increasing efforts to restrict the use of animals in research
- recent NIH activities in education of scientists and the public and in examination of NIH policy on Laboratory Animal Welfare
- participation by scientists and scientific societies in efforts to minimize restrictions on animal research
- the Boards will have an opportunity to view a brief videotape prepared for public education by the California Biomedical Research Association

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The attached background paper details:

Legislative Initiatives
Current Regulations
NIH Initiatives
Scientific Community Initiatives

Appendix I contains proposed NIH/PHS policy for Laboratory Animal Welfare

THE USE OF ANIMALS IN RESEARCH

The last few years have seen a growing public interest in the use and treatment of laboratory animals in this country, as well as the emergence of groups of citizens completely opposed to research involving animals. These groups have generated a negative image about such research, calling it needless, redundant and a torture of animals. They question the medical value or the ethical justification of such research and some promote the idea that there are "alternative methods" for performing such research. Some activist groups have even raided research laboratories, the most recent example being last month at the University of Pennsylvania School of Medicine.

Gradually the scientific community has become convinced that these views represent a real threat to the continued ability to advance knowledge through studies using animals. Momentum is gathering to examine what NIH, research institutions and the community of biologic scientists should be doing to safeguard our ability to conduct needed research involving animals while assuring the public and Congress that our standards of care and research practices are as humane as possible. A summary of proposed legislation, current federal regulation and recent activities of NIH and the scientific community follows.

Current Legislative Initiatives

Public concern and influence, as well as the concern of members of Congress, have led to the introduction in the Congress over the last 10 years of numerous bills related to research animals. In addition, several congressional hearings have focused on this issue in the last two Congresses. However, since 1976, when the Animal Welfare Act was amended, no Federal laws have been enacted.

In general, legislators have continued to raise several generic questions.

- Are excessive numbers of animals used in research?

  --Are scientists and funding agencies making a sufficient attempt to seek research methods and models which do not require the use of animals?

  --Are attempts being made to reduce the number of animals used in research?

- Are Federal funding agencies providing adequate oversight of research that involves the use of animals?

  --Are research institutions and funding agencies appropriately examining proposals for the use of animals in research?

  --Is redundant research avoided, and is the current peer review of research projects sufficient to assure that unnecessary duplication of research does not occur?

  --Are the care, treatment, and use of research animals humane?

  --Is consideration being given by researchers to the need for research methods which are less painful to animals?

Several of the bills related to research animals that have been introduced in the 98th Congress attempt to respond to these questions.

- H.R. 2350, an NIH authorization bill passed by the House of Representatives in November 1983, contains several provisions concerning animal welfare:

  --requirement that the NIH Director establish a plan for research into, validation of, and training of scientists in methods which do not require the use of animals, require fewer animals than currently needed, or produce less animal pain than current methods;

  --requirements that the Secretary, through the NIH Director, establish guidelines for (a) proper care and treatment of research animals and (b) organization and operation of animal care committees, and that the NIH Director, by regulation, require of awardee institutions (a) assurances that they meet the guidelines and that training in humane practices is available to scientists and technicians and (b) a statement of the reasons for animal use;

  --authority for the NIH Director to suspend or revoke a grant in cases where an institution fails to comply with conditions after an opportunity for such compliance has been provided; and

  --requirement that the Secretary, through the NIH Director, arrange for a study (preferably by the National Academy of Sciences) of the use of live animals in NIH-funded biomedical and behavioral research (this is sometimes referred to as the "Madigan study").

- S. 773, an NIH authorization bill pending before the Senate, contains a provision (similar to one in H.R. 2350) requiring the Secretary to arrange for a study (preferably by the National Academy of Sciences) of the use of live animals in Federally funded biomedical and behavioral research (this is sometimes referred to as the "Hatch-Kennedy study").

- S. 657, an amendment to the Animal Welfare Act, currently pending before the Senate Agriculture Committee, would provide for improved standards for animal facilities; require animal research committees at all institutions, with membership and responsibilities specified; and provide for reporting to the Secretary of Agriculture, including demonstration that investigators have considered alternatives to the use of painful procedures ("Dole bill"; companion bill H.R. 5725, "Brown Bill").

- H.R. 5098, currently pending before the House Energy and Commerce Committee, would create a National Center for Research Accountability to provide comprehensive, full-text literature searches before Federal funding of any research project using animals, to assure that the proposed research is not unnecessarily duplicative of previous or ongoing research; require that the National Library of Medicine make available full-text articles, at reasonable cost, to medical libraries; and authorize funds for these activities and for the training of biomedical information specialists ("Torricelli bill").

Current Federal Policies on the Use of Animals in Research

Currently, the Animal Welfare Act, administered by the Secretary of Agriculture, and the Good Laboratory Practices Act, administered by the Food and Drug Administration (FDA), provide for regulations concerning the transportation, housing, and care of animals in laboratories. Under the Animal Welfare Act and its attendant regulations, animal facilities (whether used in federally funded research or not) are subject to periodic inspection by the USDA Animal and Plant Health Inspection Service (APHIS). (APHIS inspectors do not currently have authority over "research in progress".) Good Laboratory Practices Act regulations apply to nonclinical studies related to products regulated by the FDA, and are enforced through FDA inspection.

Since 1965, all PHS awardee institutions have also been required to file with NIH a statement that they are committed to follow the principles of the NIH Guide for the Care and Use of Laboratory Animals. The assurance that the guidelines will be followed is a condition of receipt of an award and failure to adhere to the guidelines could result in suspension or termination of awards for research involving animals.

Recent NIH Initiatives

The NIH is undertaking broad-based efforts to examine the issues, inform scientists about the public concerns and legislative pressures, educate scientists and research institutions about humane use of animals and reexamine its policies and guidelines. These efforts have included:

- a research animal welfare education program

  --a National Symposium on Imperatives in Research Animal Use, sponsored by NIH at the NAS, was held on April 11-12 which brought together scientists, philosophers and animal protection advocates to discuss a wide range of issues.

  --regional workshops for scientists and administrators at NIH-funded institutions, designed to promote understanding, acceptance, and implementation of the PHS animal welfare policy,

  --preparation of a guidebook for institutional animal research committees, to assist them and their institutions to understand their individual and joint responsibilities in implementing the PHS animal welfare policy,

  --collection and archiving of existing, and development of new, audio-visual materials concerning humane use of animals in research, and

  --preparation of printed material to explain the necessity for using animals in research and the measures used to ensure proper selection and appropriate use of animals.

- a series of workshops (sponsored by the National Academy of Sciences under contract with the NIH Division of Research Resources) on non-animal biomedical models, to ascertain both current activity and future possibilities for such model systems;

- a revision of the NIH Guide for the Care and Use of Laboratory Animals (to be completed, by the Institute for Laboratory Animal Resources of the National Academy of Sciences under NIH contract, in early 1985);

- a series of site visits to 10 NIH-funded institutions which use research animals was reported in the April 1984 issue of NIH Guide for Grants and Contracts;

- the NIH Director's Advisory Committee meeting of June 1, 1984 was devoted to discussion of these issues;

- the PHS/NIH policy on Laboratory Animal Welfare has been revised to incorporate many of the suggestions made by the public and in proposed legislation and put out for institutional and public comment by July 15, 1984.

Dr. McCarthy of OPRR/NIH will discuss these proposed changes at our meeting (proposed policy included as Appendix I, pp. 59-70).

Recent Initiatives in the Scientific Community

Individual scientists and scientific societies have become steadily more concerned about the need to convince the public and legislators at both a national and state/local level of the scientific necessity of using laboratory animals and the ability of the scientific community to insure that such research is done parsimoniously, appropriately and humanely.

Academic societies have become increasingly involved in educating their members about the seriousness of this issue and the public about the value of animal research. There are three independent associations devoted solely to these efforts. Since the 1940s the National Society for Medical Research (NSMR) has been increasingly active in efforts to educate the public and policy makers. The Association for Biomedical Research (ABR), more recently formed, is a lobbying group devoted especially to resisting legislation or regulation related to laboratory animals. Most recently, the Foundation for Biomedical Research has been founded to work on public education and to undertake fundraising for such education as one of its major tasks. In California a statewide coalition of academic institutions, scientific groups, medical practice groups and voluntary health organizations, spurred by the introduction in the California legislature of a bill to prohibit research use of pound animals, united to conduct a highly successful public education campaign about the need to use animals in medical research. This Coalition for Biomedical Research has recently prepared a public affairs videotape which we will view at the meeting as an example of the efforts needed.

Nationally, an effort to coordinate and communicate the work of individual societies led recently to an AAMC-AMA-APS sponsored Workshop on Animals in Research to which societies or associations prominent in their current efforts were invited. A plan to explore formation of a coordinating Coalition was approved and an ad hoc steering committee has begun meeting (attendees, Appendix II). Dr. John Sherman, who chairs this committee, will speak about the necessity of efforts by individual scientists, research institutions, scientific societies and the ad hoc coalition to support the use of animals in research.

Issues for Discussion

1. What is a reasonable position with respect to the proposed NIH animal welfare policy?

2. What is the appropriate institutional response to acts of violence against research laboratories?

3. What are appropriate roles for scientific societies and individual scientists in the present sociopolitical climate? Is a coalition of concerned societies a useful effort?

4. How can the scientific community become better organized at the state and local level to deal with proposed restrictions from this quarter?

APPENDIX I

NIH PROPOSED POLICY CHANGES

The National Institutes of Health recently issued proposed revisions to the Public Health Service animal welfare policy in an effort to "update" and refine the current procedures. Since almost half of NIH-supported grants and contracts involve the use of animals (primarily rodents), the revisions would significantly affect the biomedical research community. Specifically, implementation of the proposed policy would:

- strengthen the accountability between the institution and its animal facilities by requiring institutions to designate "a senior official" who would have ultimate responsibility for the activities of the animal facility.

- make mandatory the acceptance of the "Principles of the Care and Use of Laboratory Animals" and require institutions to state that they have "implemented the requirements of the 'Guide for the Care and Use of Laboratory Animals' (Guide) and are committed to implementing the recommendations of the Guide."

- reduce the number of compliance options available to an institution from three to two, and add additional requirements for those facilities not selecting the accreditation option.

- change the composition of the animal care committee. It would now be called an "animal research committee" (ARC) and would include as members: one person unaffiliated with the institution, one person who is not a scientist by primary vocation, one practicing scientist who is experienced in laboratory animal use, and one veterinarian.

- require ARCs to review and approve the care and use of animals in research applications and proposals that involve animals.

- create additional record keeping responsibilities on the part of the research facility.

Copies of the proposed policy have been widely circulated in order to encourage written comments on the changes by July 15th. The NIH has also scheduled three public hearings to give people the opportunity to comment orally on the policy. The hearings will be held on: July 19, 1984 in Kansas City, Missouri July 24, 1984 in Boston, Massachusetts; and August 2, 1984 in Seattle, Washington.

PROPOSED

PUBLIC HEALTH SERVICE

POLICY ON HUMANE CARE AND USE OF ANIMALS

BY AWARDEE INSTITUTIONS

I. INTRODUCTION

It is the policy of the Public Health Service (PHS) that before an institution receives a PHS award involving the use of animals the institution shall submit an Animal Welfare Assurance, acceptable to the PHS[1], stating that the institution will meet the requirements detailed below in Part I and that the institution (a) accepts as mandatory the Principles for the Care and Use of Laboratory Animals (Principles), (b) has implemented the requirements of the Guide for the Care and Use of Laboratory Animals (Guide) and is committed to implementing the recommendations of the Guide, and (c) is complying and will continue to comply with the Animal Welfare Act and all other applicable Federal statutes and regulations. Institutions and research investigators have primary responsibility for the humane care and use of animals involved in PHS-funded projects. Where the proposed work involves animals, no award will be made to an institution unless a responsible official of the institution has submitted, on behalf of the institution, an Animal Welfare Assurance acceptable to the PHS. Similarly, no award will be made to an individual unless that individual is affiliated with an institution which holds an accepted Animal Welfare Assurance.

This policy is applicable to recipients of any PHS support for research, training, testing or other activities involving the use of animals, whether performed by the awardee institution or by any other institution. The PHS requires administrators and investigators of foreign institutions receiving PHS funds for research involving the use of animals to follow only the PHS Principles for the Care and Use of Laboratory Animals.

II. DEFINITIONS

A. Animal

Any live, vertebrate animal used or intended for use in research, experimentation, testing, training or related purposes. The current Guide (see definition below) does not include recommendations on facilities for cold-blooded animals; however, the Principles for the Care and Use of Laboratory

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[1] Assurances shall be submitted to the Office for Protection from Research Risks (OPRR), National Institutes of Health (NIH), Department of Health and Human Services (DHHS). Bethesda, Maryland 20205.

Animals (see definition below) and this policy apply to all live vertebrates.

B. Animal Facility

Any building, room, area or vehicle designed or used to confine, transport, maintain or use animals, including satellite facilities. A satellite facility is any facility in which animals are housed for more than 24 hours outside the central facility.

C. Animal Welfare Act

Public Law 89-544, 1966, as amended, (P.L. 91-579 and P.L. 94-279) 7 U.S.C. 2131 et. seq. Implementing regulations are published in the Code of Federal Regulations (CFR), Title 9, Subchapter A, Parts 1, 2, 3 and 4, and are administered by the U.S. Department of Agriculture.

D. Assurance

Animal Welfare Assurance, the documentation on file wit (or submitted when requested by) the OPRR, from an awardee or a prospective awardee institution, assuring institutional compliance with this policy.

E. Guide

Guide for the Care and Use of Laboratory Animals, DHEW, NIH Pub. No. 78-23, 1978 edition or succeeding revised editions.

F. Institution

Any public or private institution, organization or agency (including Federal, state or local government agencies) in the United States, the Commonwealth of Puerto Rico, or any territory or possession of the United States.

G. Principles

Principles for the Care and Use of Laboratory Animals (see below).

H. Responsible Institutional Official

An individual who bears final responsibility for the entire program of animal care and use at the institution, and who has the authority to sign the institution's assurance and to make a commitment on behalf of the institution that the requirements of the PHS policy will be met.

III. PRINCIPLES FOR THE CARE AND USE OF LABORATORY ANIMALS

A. The Personnel

1. Experiments involving live, vertebrate animals and the procurement of tissues from living animals for research must be performed by, or under the immediate supervision of, a qualified biological, behavioral, or medical scientist.

2. The housing, care, and feeding of all experimental animals must be supervised by a properly qualified veterinarian.

B. The Research

1. The research should be such as to yield fruitful results for the good of society and not random or unnecessary in nature.

2. The experiment should be based on knowledge of the disease or problem under study and so designed that the anticipated results will justify its performance.

3. Statistical analysis, mathematical models, or in vitro biological systems should be used when appropriate to complement animal experiments and to reduce numbers of animals used.

4. The experiment should be conducted so as to avoid all unnecessary suffering and injury to the animals.

5. The scientist in charge of the experiment must be prepared to terminate it whenever he/she believes that its continuation may result in unnecessary injury or suffering to the animals.

6. If the experiment or procedure is likely to cause greater discomfort than that attending anesthetization, the animals must first be rendered incapable of perceiving pain and be maintained in that condition until the experiment or procedure is ended. The only exception to this guideline should be in those cases where the anesthetization would defeat the purpose of the experiment and data cannot be obtained by any other humane procedure. Such procedures must be carefully supervised by the principal investigator or other qualified senior scientist.

7. Post-experimental care of animals must be such as to minimize discomfort and the consequences of any disability resulting from the experiment, in accordance with acceptable practices in veterinary medicine.

8. If it is necessary to kill an experimental animal, this must be accomplished in a humane manner, i.e., in such a way as to ensure immediate death in accordance with procedures approved by an institutional committee.

C. The Facilities

1. Standards for the construction and use of housing, service, and surgical facilities should meet those described in the publication, Guide for the Care and Use of Laboratory Animals, DHEW No. 78-23 (reprinted in 1980 DHEW 80-23), or succeeding editions or as otherwise required by the U.S. Department of Agriculture regulations established under the terms of the Animal Welfare Act (P.L. 89-544) as amended.

D. Transportation

1. Transportation of animals must be in accord with applicable standards and regulations, especially those intended to reduce discomfort, stress to the animals, or spread of disease. All animals being received for use as experimental subjects and having arrived at the terminal of a common carrier must be picked up and delivered, uncrated, and placed in acceptable permanent facilities promptly.

IV. IMPLEMENTATION BY AWARDEES

Before an institution is eligible to receive PHS support for projects in which animals are to be involved, the institution must submit to the Office for Protection from Research Risks (OPRR), Office of the Director, National Institutes of Health, an Animal Welfare Assurance acceptable to OPRR, stating that the institution will meet the requirements detailed in this policy and that the institution

- accepts as mandatory the Principles for the Care and Use of Laboratory Animals (Principles),
- has implemented the requirements of the Guide for the Care and Use of Laboratory Animals (Guide) and is committed to implementing the recommendations of the Guide, and
- is complying and will continue to comply with the Animal Welfare Act and all other applicable Federal statutes and regulations.

This policy does not affect applicable state or local laws or regulations which impose more stringent standards for the care and use of laboratory animals.

A. Animal Welfare Assurance

The Animal Welfare Assurance (assurance) shall be typed on the institution's letterhead and signed by a responsible institutional official who has the authority to make a commitment on behalf of the institution and who bears final responsibility for the entire program of animal care and use at the institution. OPRR will provide the applicant institution with necessary definitions, instructions, and an example of an acceptable assurance. Subsequent to the institution's submission of an assurance, OPRR will notify the institution as to the acceptability of the assurance. No project proposing to use animals will be supported, and no active PHS project will be permitted to continue, in the absence of an acceptable assurance. Significant changes in the status of an existing assurance, departures from information submitted in an annual report (see Option 2), or problems encountered in implementing this policy shall be reported immediately to OPRR. After reviewing changes or problems, OPRR may require renegotiation of the assurance or other appropriate actions. In any case each institution must submit a new and complete assurance to OPRR at least every 5 years.

1. Program for Animal Care and Use

The assurance must contain a description of the institution's program for animal care and use, designating:

a. appropriate lines of authority and responsibility for administering the program and ensuring compliance with this policy; and

b. the veterinarian(s) qualified in laboratory animal medicine who will be responsible for supervising the housing, feeding, and care and use of all animals.

2. Institutional Status

The assurance must include a statement indicating that the institution has adopted one of the following options:

Option 1 - The institution is fully accredited by the American Association for Accreditation of Laboratory Animal Care (AAALAC) or other accrediting body recognized by PHS2 and (a) accepts as mandatory the Principles for the Care and Use of Laboratory Animals (Principles), (b) has implemented the requirements of the Guide for the Care and Use of Laboratory Animals (Guide) and is committed to implementing the recommendations of the Guide, and (c) is complying and will continue to comply with the Animal Welfare Act and all other applicable Federal statutes and regulations.

An institution may not adopt Option 1 unless the institution has received full accreditation, by AAALAC or other accrediting body recognized by PHS, for all of its programs and facilities, including satellite facilities. An institution that has received provisional or probationary accreditation, or whose accreditation is revoked or is currently being withheld for any of its facilities, including satellite facilities, must select Option 2.

Option 2 - The institution has conducted a self-assessment (as described in the institution's assurance and annual reports) and the institution (a) accepts as mandatory the Principles for the Care and Use of Laboratory Animals (Principles), (b) has implemented the requirements of the Guide for the Care and Use of Laboratory Animals (Guide) and is committed to implementing the recommendations of the Guide, and (c) is complying and will continue to comply with the Animal Welfare Act and all other applicable Federal statutes and regulations.

Institutions covered by Option 2 must submit with the assurance and thereafter annually a report to OPRR. These reports will become a part of the assurance. Failure to submit an annual report may result in withdrawal by OPRR of the acceptance of the assurance.

Each report shall contain, at a minimum:

(a) a description of the nature and extent of the institution's adherence to the Principles and to the requirements and recommendations contained in the Guide;

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2 As of March 1984, the only accrediting body recognized by PHS is the American Association for Accreditation of Laboratory Animal Care (AAALAC).

(b) a description of deficiencies, if any, in the institution's adherence to the requirements and recommendations contained in the Guide;

(c) a plan of action, including a specified time frame, for correcting deficiencies described in "(b)" above;

(d) progress towards remedying deficiencies previously described in "(b)" above; and

(e) the Animal Research Committee's recommendations for changes or improvements as forwarded to the responsible institutional official and other appropriate institutional officials (see B. Functions of the Animal Research Committee).

Upon consideration of the annual report and the institution's implementation of its assurance OPRR may impose specific restrictions or requirements pertaining to the care and use of laboratory animals.

3. Animal Research Committee (ARC)

Each institution shall appoint an Animal Research Committee (ARC), sufficiently qualified through the experience and expertise of its members to maintain oversight of the institution's animal program, facilities and procedures, and to provide complete and adequate review of research activities involving animals conducted by the institution.

The assurance must include the names, position titles and credentials of the ARC members, the ARC chairperson, and the responsible institutional official (see definitions). The membership of the ARC shall include:

a. at least five members;

b. at least one Doctor of Veterinary Medicine who is responsible for supervising the housing, feeding, and care and use of all animals at the institution, and who has appropriate qualifying expertise in laboratory animal medicine (demonstrated either by certification from the American College of Laboratory Animal Medicine, or by other evidence of expertise determined by OPRR to be satisfactory);

c. at least one practicing scientist experienced in research involving animals;

d. at least one member whose primary vocation is in a nonscientific area; and

e. at least one individual who is not otherwise affiliated with the institution and is not a member of the immediate family of a person who is affiliated with the institution.

Changes in the membership of the ARC must be reported promptly to OPRR.

B. Functions of the Animal Research Committee

The Animal Research Committee (ARC) will be the principal advisory group on humane care and use of animals to the institution and to researchers who use animals. The ARC is the appropriate body for resolving concerns involving the care and use of animals brought to the attention of the committee by veterinarians, researchers, animal caretakers or others. As necessary, the ARC will recommend to the responsible institutional official and other appropriate institutional officials, changes and improvements regarding the institution's animal program or facilities. Annual reports to OPRR (required under Option 2 only) must include any committee recommendations as forwarded to the responsible institutional official.

The ARC or the ARC Doctor(s) of Veterinary Medicine in conjunction with the ARC must be prepared to alter or to suspend a research activity whenever either of them determines that the activity is not in compliance with this policy. The ARC has responsibility to terminate the research activity if it determines that the activity cannot be brought into compliance with this policy.

In the conduct of its duties, the ARC at a minimum shall:

1. review annually the institution's program for humane animal care and use;

2. inspect annually all of the institution's animal facilities, including satellite facilities;

3. review and approve the care and use of animals as set forth in applications or proposals when PHS funds are requested (see C. Review of PHS Research Applications and Proposals);

4. review and approve proposed changes in ongoing research funded by PHS which introduce significant concerns regarding the use of the animals involved, or when animal studies were not originally proposed and approved by the ARC; and

5. when requested by PHS, review specific animal welfare issues identified during the PHS review process.

C. Review of PHS Research Applications and Proposals

Review and approval of the care and use of animals as set forth in all applications or proposals is required. However, unless one of the categories listed below pertains, the review may be conducted by the chairperson of the ARC, or another member of the ARC designated by the chairperson and qualified to conduct the review.

The care and use of animals as set forth in applications and proposals must be reviewed at a convened meeting of at least a majority of the full membership of the ARC and must be approved by a majority of the full membership whenever a research activity would:

1. include the use of nonroutine or harmful invasive procedures; or

2. include prolonged restraint; or

3. require the use of animals that have a serious natural or experimental disease and which would be maintained in that state for an extended period of time; or

4. propose methods of euthanasia that differ from those recommended by the American Veterinary Medicine Association (AVMA) Panel on Euthanasia[3]; or

5. involve any animal procedure or use which is stipulated by the ARC or by OPRR as requiring ARC review and approval.

The ARC shall approve the application or proposal only when the care and use of animals has been reviewed and found to comply with this policy and with the conditions of the institution's assurance. The ARC may not have a member participate in the ARC's review or approval of a project in which the member has a conflicting interest (e.g., the principal investigator for the project), except to provide information requested by the ARC.

An ARC may invite ad hoc technical consultants with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the ARC. These ad hoc consultants may not vote with the ARC.

Verification of approval by the ARC shall be indicated by the signature of the responsible institutional official on the face page of the application or proposal. OPRR will ask institutions that do not have an acceptable assurance on file to submit verification of approval after the institution has complied with an OPRR request to submit an assurance and establish an ARC (see D. Information Required in Applications and Proposals Submitted to PHS).

D. Information Required in Applications and Proposals Submitted to PHS.

1. All Institutions

Applications and proposals submitted to PHS that involve the care and use of laboratory animals shall contain the following information:

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[3]Journal of the American Veterinary Medical Association (JAVMA), 1978, Vol. 173, No. 1, pp. 59-72.

a. identification of the species and number of animals to be used;

b. rationale for involving animals, and for the appropriateness of the species and numbers to be used;

c. a complete description of the proposed use of the animals;

d. assurance that discomfort and injury to animals will be limited to that which is unavoidable in the conduct of scientifically valuable research, and that analgesic, anesthetic, and tranquilizing drugs will be used where indicated and appropriate to minimize discomfort and pain to animals; and

e. if euthanasia is to be involved, a description of the method to be used.

2. Institutions Which Have an Acceptable Assurance

Applications and proposals involving animals from institutions with an acceptable assurance on file with OPRR shall contain verification of approval by the ARC, indicated by the signature of the responsible institutional official on the face page of the application or proposal. PHS will consider applications or proposals incomplete if they lack verification of approval. If verification of approval is not received at the time of submission to PHS of a grant application or contract proposal, the application or proposal may be returned to the institution.

3. Institutions Which Do Not Have an Acceptable Assurance

Applications and proposals involving animals from institutions that do not have an acceptable assurance on file with OPRR shall contain a declaration that the institution will establish an ARC and submit an assurance upon request by OPRR. After such assurance has been accepted by OPRR, the ARC (or appropriate ARC member) shall review and approve the care and use of animals in the research. The responsible institutional official must submit, by letter, verification of approval of the proposed care and use of animals in the research by the ARC before an award will be made.

E. Recordkeeping.

The awardee institution shall maintain:

1. an Animal Welfare Assurance approved by the PHS;

2. minutes of ARC meetings, including records of attendance, activities of the committee, and committee deliberations;

3. records of applications, proposals and proposed changes in ongoing research reviewed and approved or disapproved;

4. records of ARC recommendations as forwarded to the responsible institutional official; and

5. records of accreditating body determinations.

All records shall be maintained for at least 3 years. Records that directly relate to applications, proposals, and proposed changes in ongoing research reviewed and approved by the ARC shall be maintained for at least 3 years after completion of the research. All records shall be accessible for inspection and copying by authorized OPRR or other PHS representatives at reasonable times and in a reasonable manner.

V. IMPLEMENTATION BY PHS

A. Responsibilities of the OPRR.

OPRR is responsible for the general administration and coordination of this policy and will:

1. request and approve Animal Welfare Assurances and related reports;

2. distribute to executive secretaries of initial review and technical evaluation groups, and to PHS awarding units, lists of institutions that have filed an acceptable Animal Welfare Assurance;

3. advise awarding units and awardee institutions concerning the implementation of this policy; and

4. evaluate allegations of noncompliance with this policy.

B. Responsibilities of PHS Awarding Units

PHS awarding units may not make an award for a project involving animals unless the institution submitting the application or proposal is on the list of institutions that have an acceptable assurance on file with OPRR, and the responsible institutional official has provided verification of approval by the ARC. If an institution is not listed, the awarding unit will ask OPRR to negotiate an assurance with the institution before an award is made. No award shall be made until the assurance has been submitted by the institution, accepted by OPRR, and the responsible institutional official has provided verification of approval, by the ARC, of the care and use of animals as set forth in the application or proposal.

No initial, competing continuation, or recompeting award will be made if the application or proposal does not satisfy the terms of this policy.

C. Conduct of Special Reviews/Site Visits

Each awardee institution is subject to a special review, which may include a site visit, when questions are raised regarding its compliance with this policy. Institutions covered by Option 2 may be selected at random for site

visits by PHS staff and advisors to assess the adequacy of compliance with their assurance, but institutions that are covered by Option 1 will not be subject to such random site visits.

D. Waiver

Institutions may request a waiver of a provision or provisions of this policy by submitting a request to OPRR. No waiver will be granted unless sufficient justification is provided and the waiver is approved in advance and in writing by OPRR. In any event, such waivers will be granted only in exceptional circumstances.

* U.S. GOVERNMENT PRINTING OFFICE: 1984-421-144:2

INVITEES

April 27-28, 1984
AMA/APS/AAMC Meeting
on
Animals in Research

AMERICAN CANCER SOCIETY

AMERICAN COLLEGE OF SURGEONS

AMERICAN FARM BUREAU FEDERATION

AMERICAN FEDERATION FOR CLINICAL RESEARCH

AMERICAN HEART ASSOCIATION

AMERICAN INSTITUTE OF BIOLOGICAL SCIENCES

AMERICAN MEDICAL ASSOCIATION

AMERICAN PHYSIOLOGICAL SOCIETY

AMERICAN PSYCHOLOGICAL ASSOCIATION

AMERICAN SOCIETY FOR CELL BIOLOGY

AMERICAN SOCIETY FOR MICROBIOLOGY

AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

ASSOCIATION FOR BIOMEDICAL RESEARCH

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ASSOCIATION OF AMERICAN UNIVERSITIES

ASSOCIATION OF PROFESSORS OF MEDICINE

CALIFORNIA BIOMEDICAL RESEARCH ASSOCIATION

COUNCIL OF STATE GOVERNMENTS

FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS SOCIETY FOR MEDICAL RESEARCH

MICHIGAN SOCIETY FOR MEDICAL RESEARCH

NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND-GRANT COLLEGES

NATIONAL SOCIETY FOR MEDICAL RESEARCH

PHARMACEUTICAL MANUFACTURERS ASSOCIATION

SOCIETY FOR NEUROSCIENCE

Observers:

INSTITUTE OF LABORATORY ANIMAL RESOURCES

INSTITUTE OF MEDICINE

Thank you for your continued interest and your willingness to consider collective activities. If, on further reflection, you have any suggestions or comments stimulated by the summaries or the nature of the April meeting, please don't hesitate to contact us.

Sincerely yours,

John F. Sherman, Ph.D.
Vice President

Enclosures

association of american medical colleges

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

202: 828-0460

May 29, 1984

Dear :

Enclosed you will find summaries of the workshop reports and the discussion that followed the presentations of those reports at the April 27-28 meeting in Washington on the use of animals in research, testing and education.

As suggested at that meeting, an ad hoc steering committee has been established consisting of representatives of:

American College of Surgeons
American Heart Association
American Medical Association
American Physiological Society
American Society for Cell Biology
American Society for Microbiology
Association for Biomedical Research/Foundation for Biomedical Research
Association of American Medical Colleges
National Society for Medical Research
Pharmaceutical Manufacturers Association

That committee met on May 23 to initiate discussions about the planning and implementation of future cooperative activities. Various organizational models were also discussed. While no model was selected, it was agreed that no new bureaucratic, formal organization was either desirable or necessary. A survey will be initiated in the near future of those organizations represented at the April meeting in order to gain some approximation of the degree of commitment, resources and nature of activities currently under way. The ad hoc committee has begun drafting papers on strategies to be considered and on proposals for the organizational format of a coalition of concerned organizations. Those papers will be mailed to you and others who attended the April meeting within the next few weeks for your consideration. Additionally, a resolution is being prepared on the importance of animals for research, testing, and education, which hopefully will be adopted eventually by a large number of organizations. Another meeting of the Steering Committee is scheduled for June 29, and information will be provided to you as to the nature of discussions held at that meeting.

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