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AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 12, 1984

Noon
Hemisphere Room

COMBINED LUNCHEON OF AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION and AAMC ADMINISTRATIVE BOARDS

1:00-3:45 p.m.
Conservatory Room

COMBINED MEETING OF AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION and AAMC ADMINISTRATIVE BOARDS

OVERVIEW - Robert H. Heyssel, M.D.

"Societal Contribution Costs of Teaching Hospitals and Commonwealth Fund Task Force on Academic Health Centers"

John W. Colloton
University of Iowa Hospitals and Clinics

"Review of Related Research Activities Underway"

Gerard Anderson, Ph.D.
Center for Hospital Finance and Management
The Johns Hopkins Medical Institutions

"Alternative Ways of Financing Graduate Medical Education"

Robert G. Petersdorf, M.D.
School of Medicine
University of California, San Diego

4:00-5:45 p.m. SMALL GROUP DISCUSSIONS

6:00-7:00 p.m.
Thoroughbred Room

JOINT ADMINISTRATIVE BOARD RECEPTION

7:00-9:00 p.m.
Thoroughbred Room

JOINT ADMINISTRATIVE BOARD DINNER

September 13, 1984

9:00 a.m. - 1:00 p.m.
Independence Room

CAS ADMINISTRATIVE BOARD MEETING

1:00 - 2:30 p.m.
Cabinet Room

JOINT ADMINISTRATIVE BOARD LUNCHEON

2:30 p.m. Adjournment

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 12-13, 1984

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MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 27-28, 1984
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

Virginia V. Weldon
(Presiding)
Philip C. Anderson
David H. Cohen
Harold S. Ginsberg
Joseph E. Johnson
Douglas Kelly
Jack L. Kostyo
Frank C. Wilson

Staff

Janet Bickel*
John A.D. Cooper*
Carolyn Demorest
John Deufel*
James Erdmann*
Carolyn Henrich
Mary Littlemeyer*
David Moore
James R. Schofield*
John F. Sherman*
Elizabeth M. Short*
August G. Swanson*
Kat Turner*

Guests

Richard Janeway
Donald G. Langsley

The CAS Administrative Board convened jointly with the Council of Deans Administrative Board at 5:00 p.m. on June 27 for a business meeting to discuss the use of animals in research. The joint Boards were joined by Dr. John F. Sherman and were to have heard from Dr. Charles McCarthy of NIH (see page 2). Dr. McCarthy, however, was unable to attend the meeting. 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 June 28 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

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I. THE USE OF ANIMALS IN RESEARCH

A joint session of the CAS/COD Administrative Boards discussed the use of animals in laboratory research and specifically commented on the revised PHS/NIH policy on laboratory animal welfare. Dr. Edward Stemmler, chairman of the COD Administrative Board, opened the meeting with a review of the events surrounding the raid on an animal laboratory at the University of Pennsylvania during the Memorial Day weekend.

The PHS policy was then reviewed. Several members suggested that implementation of the revised animal policy would not mollify the animal rights lobby. Discussants were divided over whether to strenuously object to the proposed policy as unnecessary intrusion on research or to accept its provisions, regardless of how distasteful, in the hope that the presence of the policy would stop further public efforts to limit the use of animals in research.

The following specific comments were made:

1) The practicality of reviewing all animal research prospectively was questioned. It was proposed that one might want to have the policy mandate prospective review only in the case of research involving certain species of animals, for example primates.

2) The proposed composition of the animal committees was also challenged. It was felt by some members that these committees would be unable to comment on the scientific merit of a grant proposal and that the committees should be restricted to considerations of animal care.

3) The issue was raised of whether it would be possible to review grant proposals without considering scientific merit.

4) It was suggested that because the committees are not qualified to judge scientific merit, they should have only an advisory function. Rather than reject a grant application, the committee would forward it to the NIH peer review group with its objections noted. This would require the committee to state why it was objecting to the proposal, but deny it veto power over grant submission.

5) Some members objected to the tone of the proposed policy, commenting that it is written almost as if the scientific community is guilty as charged of animal abuse. It was noted that the NIH has placed its constituency, the academic medical centers, in the awkward position of having to defend their position by commenting on a policy which appears biased.

6) The administrative burden that the new policy might place on smaller institutions was also discussed. The point was raised whether this might ultimately affect the geographic distribution of animal research, driving it from smaller to larger institutions.

The Boards then turned to further discussion of the general threat to the continuation of animal research posed by the present climate of public opinion. The Boards agreed that a major emphasis needs to be placed on public education, but there was no consensus of the best way to accomplish this. The recent

experience in California concerning a legislative effort to restrict the use of animals acquired from pounds was discussed. The defeat of the legislation was cited as an example that a serious commitment from the scientific community can overcome public pressure. It was pointed out, however, the economic matters were probably the most important factor in the defeat of the legislation.

Dr. Sherman reviewed some of the efforts that have resulted from an April meeting of many scientific and medical groups concerned with the threats to animal research which was jointly sponsored by the AMA, the APS, and the AAMC. An ad hoc steering committee has been established to develop strategies on this issue. Dr. Sherman also noted that more groups are attempting public education, but that these efforts are small scale and sporadic. Finally, the Boards viewed a 15-minute videotape prepared by the California Biomedical Research Association. The tape is an example of the type of material that can be produced for public education.

II. BUSINESS MEETING

A. ACTION ITEMS - CAS Board

1. Approval of Minutes

The minutes of the April 11-12, 1984 CAS Administrative Board meeting were approved as published.

2. Report of the 1984 CAS Nominating Committee

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.

ACTION: The CAS Administrative Board accepted without objection the Nominating Committee's slate of nominees.

3. Membership Application

Drs. Kelly and Moody had been asked to review the application of the University Association for Emergency Medicine for membership in the CAS. Both recommended that the application be approved.

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

4. Distinguished Service Membership Nominations

By previous action of the CAS Board, it had been agreed that an individual is eligible for nomination to the category of distinguished service membership if he/she has served as chairman of the CAS, chairman of the AAMC representing CAS, or as a member of the CAS Board for two consecutive terms.

ACTION: The CAS Administrative Board voted to nominate David M. Brown (CAS Chairman, 1981-82) and Frank C. Wilson (CAS Chairman, 1982-83) to the category of distinguished service member in the AAMC.

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5. CAS Member Society Endorsement of the AAMC Document "Preserving America's Preeminence in Medical Research."

The CAS Board had previously sent a request to all member societies to discuss the principles embodied in this document and endorse it as the position of their society. Thus far only 16 societies have informed the staff of endorsement.

ACTION: The CAS Administrative Board authorized the staff to send a second letter on behalf of the Board requesting consideration of endorsement.

B. DISCUSSION ITEMS - CAS Board

1. CAS Challenges/Future Directions Paper

The CAS Board reviewed the draft paper and commended the general approach and tone of the document. They felt that it was an exemplary statement of the key issues and challenges facing the faculties in education, research and patient care and an excellent summary of the deliberations of the Council of Academic Societies at its Spring meeting. The Board focused its discussion on a series of possible options for the organization of CAS to maximize its ability to represent its constituency and formulate positions on key issues. A series of options was approved by the Board for inclusion in the paper which will be reviewed by the Board at its September meeting and submitted to the Council at the Annual meeting.

ACTION: The section on Strategies for Future Directions of the Council of Academic Societies will be revised to summarize the recommendations of the CAS Administrative Board.

2. Matching Medical Students to PGY-2 Positions

The Administrative Board discussed the present schedules for medical student application for residencies, especially in the light of their discussion of the GPEP report and their concerns about the educational content of the fourth year of medical school. The Board strongly asserted that the practice of requiring medical students to select a subspecialty at the end of the third year and obtain a PGY-2 residency before the NRMP match was disruptive of the goals of general medical education and led to premature emphasis on specialization. They further felt that it deprived students and medical schools of the advantages of a single uniform residency selection process taking place as late in the senior year as possible.

ACTION: The CAS Administrative Board recommends that the other Administrative Boards and Executive Council consider at the September meeting the adoption of a strongly worded motion supporting the use of a single residency matching plan.

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3. CAS Annual Meeting Plans

The CAS Administrative Board approved the present schedule which calls for a plenary session followed by small group discussions on GPEP on Sunday afternoon, October 28.

The Board further agreed that the members of the subcommittee to development commentary on GPEP would chair the four working groups and would lead a council-wide discussion of the substantive issues in the GPEP report.

4. CAS Interim Meeting Plans

The CAS Administrative Board approved the following dates for the CAS Interim (Spring) meetings:

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

The Board further decided not to move the meeting from Washington, D.C.

C. DISCUSSION ITEMS - Executive Council

1. Report of the Project Panel on the General Professional Education of the Physician and College Preparation for Medicine

Dr. August Swanson gave some background on the origin of the panel's Report, a final copy of which was included in the agenda. He indicated that the Report is scheduled for public release on September 19, 1984. It will be released at press conferences in Washington, D.C. and New York and some of its recommendations discussed in a presentation to the European Association of Medical Education on the same day. This presentation will take place via a transatlantic satellite video conference. All AAMC constituents will receive copies of the Report in September.

The CAS Administrative Board was asked to consider what actions the Association should take on this report. Dr. Swanson reported that the Executive Committee had suggested that the simplest route would be to receive the report now and consider a process for endorsement at the September meeting of the Administrative Boards and the Executive Council, one week before public release.

At this juncture a number of issues in the report were identified and discussed at length. These included the following:

- While the report identifies the concentration of lectures in the curriculum as a problem, the Board felt that the reasons behind this concentration were not adequately addressed. These reasons include the elective nature of the fourth year and the lack of priorities for curriculum planning.

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- The Board was specifically concerned that arbitrary attempts to reduce pre-clinical lecture hours further would seriously impair basic science instruction since the hours devoted to laboratory instruction have already been progressively eliminated and numerous clinically-oriented activities added to the program of the first two years.

- A recommendation to emphasize the development of problem solving skills does not address the dilemma caused by the additional demands for time that such courses place on the curriculum.

- A reexamination of the fourth year, with particular attention to the development and evaluation of basic clinical skills versus the increasing tendency toward specialization should be further stressed.

- The need for a broader consideration of the recommendations of the Report. It was stressed that this Report should not be viewed as set answers to various problems, but rather as a series of observations and recommendations to be used as a basis for further discussion of these issues.

- The conflict between an emphasis on teaching on one hand and increasing pressure for research and clinical practice on the other has major implications for education which were not addressed. There was general uncertainty as to whether measures could realistically be developed to diminish this conflict.

The Board concluded that many areas of the GPEP Report merited further discussion and comment. They did not feel prepared to endorse the Report at this time, especially if an endorsement connoted that this was viewed as a consensus document of AAMC positions on these issues. The Board felt that a CAS committee should be formed and charged with developing specific commentary on the Report, especially with a view to providing faculty perspective on the Report and on what actions would be needed to implement desired goals of the Report. Such a committee could try to work with an Association-wide group to formulate an AAMC commentary by September, but this time frame was viewed as very short for serious deliberation of content. The Board felt that a preferable AAMC position would be to receive the Report as an agenda of issues for AAMC discussion over the coming year. The CAS committee could then engage the entire Council in discussion at the Annual meeting and formulate a CAS position for Executive Council consideration.

ACTION: The CAS Board will recommend to the Executive Council that the GPEP Report be received as an agenda for deliberation in the coming year. The CAS will establish a small committee which will consider the recommendations of the Report, lead a discussion by the Council at the Annual meeting and develop specific commentary with a focus on issues in implementation of the Report.

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2. Faculty Salaries from NIH Grants and Contracts

The CAS Board reviewed data indicating that there was lack of uniformity among the member institutions and within the federal agencies about the amount of faculty salary which may be charged to grants and contracts. Discussion ensued about inequities in the policies and the increasing federal tendency to disallow portions of faculty salary from the base for percent calculations. The CAS Board generally agreed that more information was needed on this topic before any policy could be considered. The Board was reluctant to recommend further action beyond information gathering at this time. They expressed some doubt as to the feasibility of a single national policy, and questioned whether this issue might be best resolved at the institutional level.

3. Graduate Medical Education

Dr. John A.D. Cooper, AAMC President, summarized for the Administrative Board the growing challenges to the traditional support for graduate medical education (housestaff education) from patient care revenues. The impending crisis in financing graduate medical education has led the Executive Committee to recommend the formation of an Association Task Force to examine the issues and formulate policy recommendations for consideration by the Association and a day-long Plenary Session on the subject at the September meeting of the Administrative Boards. The Board is aware of the imminent threat to funding of this portion of medical education and considered the Association proposal timely.

ACTION: The CAS Administrative Board agreed that the Association form a Task Force to study the current issues involved with graduate medical education, especially focusing on the financing of graduate medical education.

4. NIH Proposed Policy on Laboratory Animal Use

Dr. John Sherman reviewed the discussion from the previous evening on this topic and informed the Board that the Association would circulate a memorandum stressing the importance of the scientific community commenting on this policy. There were no additional comments by the Board.

5. Faculty Practice Plans

The CAS Administrative Board was very interested in the organization of faculty practice plans at various institutions and the relationship that such plans will have to the missions of the medical schools. The Board appreciated being informed of the plans to survey the deans to identify the significant policy issues with relation to faculty practice plans. The Board recognizes that these issues are also of great concern to the faculties and may well merit a more extensive consideration at a later date.

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6. Extramural Facilities Construction

The CAS Administrative Board discussed the need for funds for construction and renovation of research facilities at the institutions. This topic was discussed at the April Board meeting and the Board was aware of studies underway to document and quantify this need.

Discussion with Dr. Sherman and Mr. Deufel focused on the adverse policy implications of funding extramural research construction through indirect cost reimbursement, because of the increase in indirect costs which would draw money away from research project funding. The Board was specifically concerned that this was a politically inopportune time to raise indirect costs. Dr. Weldon stated that Congress needs to be made aware that there is an unmet need for rehabilitation, renovation, and building of new facilities; and if the Congress wants that financed out of indirect costs, then the Congress must add specific incremental sums for such construction to the NIH budget so that the R01 grants can remain fully funded.

The Board preferred a policy of seeking specific authority for construction in the expectation that this would focus the Congressional debate and lead to the direct appropriation of appropriate sums to carry out such construction. The Board felt that the major policy emphasis should be on obtaining additional funds for extramural research construction regardless of the mechanism of funding.

D. INFORMATION ITEMS - Executive Council

1. Relationships with Investor-Owned Organizations

The CAS Administrative Board reviewed preliminary data from a survey of deans conducted following the COD Spring meeting discussion on the relationship of medical schools to investor-owned hospitals. The Board expressed surprise at the extent of involvement and agreed that this was useful information.

2. Capital Payments

Dr. Weldon reviewed the situation with respect to payment of capital costs by hospitals. The document presented to the Board was the result of an AAMC study of capital costs in COTH and non-COTH hospitals. The data initially suggested that capital needs in teaching hospitals were lower than non-teaching hospitals. But when the capital costs were calculated on an output basis, the costs for teaching hospitals were found to be higher.

The problem is not in determining that there are capital needs in teaching hospitals that need to be addressed, but in determining a mechanism for payment of these costs which can be suggested to the federal government. The report offers a number of transition options for phasing in different plans of payment. However, no one hospital is in the same situation with respect to projects and capital needs as are any others. All of the options presented do not lead from one form of reimbursement to another without some institutions getting

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hurt. The COTH is attempting to come up with a mechanism for the policymakers that will affect all hospitals as evenly as possible. Unfortunately, the committee cannot agree on any of the six options proposed.

3. Patent Reform/Generic Drug Legislation

The CAS Administrative Board agreed that the Association should support the compromise legislation despite the fact that some of the major drug companies felt that it provided inadequate protection of their patent rights and might serve as a disincentive to new drug development.

4. Retirement of Dr. John A.D. Cooper

Dr. Cooper announced to the CAS Administrative Board that he will retire as President of the AAMC, effective June 30, 1986. On behalf of the Board, Dr. Weldon expressed appreciation for the dynamic and effective leadership that Dr. Cooper has provided the Association for the past 15 years. Dr. Cooper is announcing his retirement now so that a search for his successor may begin.

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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: Mr. David Moore

NAME OF SOCIETY: The American College of Psychiatrists

MAILING ADDRESS: Central Office, Post Office Box 365, Greenbelt, Maryland 20770

PURPOSE: See page 2 of enclosed program.

MEMBERSHIP CRITERIA:

Physicians who specialize in the field of psychiatry and have certain status and recognition as specified in the attached By-Laws of the College.

NUMBER OF MEMBERS: Active: 500 Emeritus: 103

NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: May 8, 1963

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

February 1984 1. Constitution & Bylaws

February 1984 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

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QUESTIONNAIRE FOR TAX STATUS

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

✓ 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?

✓ 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.

Robert O Pasnau MD

(Completed by - please sign)

Robert C. Pasnau, M.D.
President 7-23-84

(Date)

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REVISION OF THE RULES AND REGULATIONS PERTAINING TO THE CAS NOMINATING COMMITTEE

Section V. Committees

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

Section IV. Officers

2. Duties of the Chairman. The Chairman shall be the chief administrative officer of the Council and shall preside at all meetings. He shall serve as Chairman of the Administrative Board and shall be an ex officio member of all committees *except the Nominating Committee*. He shall have primary responsibility for arranging....

REVIEW OF "FUTURE CHALLENGES FOR THE CAS"

In June, the CAS Administrative Board reviewed a preliminary draft of the CAS white paper on the key issues and challenges facing faculties in the areas of education, research and patient care in the coming years. The Board focused its attention on a series of options available to the CAS to increase its ability to represent its constituency and to formulate positions on urgent issues. The Board approved several of these options in the form of recommendations concerning the activities and governance of the CAS and requested revision of the document to incorporate these recommendations. This draft of the paper contains two substantive changes. At Dr. Hill's suggestion, an additional item (III, p. 6) has been added to the Strategies section under Challenges in Education. The Strategies section under Future Directions for the Council of Academic Societies (pp. 29 to 31) has been rewritten to reflect the Board's recommendations.

The Board also agreed to a tentative timetable that would include a further review by the Administrative Board in September and submission to the full Council of Academic Societies at the time of the Annual Meeting.

Recommendation:

That the CAS Administrative Board consider whether to approve the "Future Challenges" paper for distribution to and discussion by the entire Council at the Annual Meeting in October.

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FUTURE CHALLENGES
FOR
THE COUNCIL OF ACADEMIC SOCIETIES

A DISCUSSION PAPER
OCTOBER 1984

FUTURE CHALLENGES FOR THE COUNCIL OF ACADEMIC SOCIETIES

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DRAFT

FUTURE CHALLENGES FOR THE COUNCIL OF ACADEMIC SOCIETIES

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, 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 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 consensus 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

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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 is a responsibility unique to the academy. It follows that a principal concern

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of the Council of Academic Societies should be the continual improvement of biomedical education.

During the past three decades the educational responsibilities 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

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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 medical student 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

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accrediting agencies. For medical school faculties these agencies include the Liaison Committee for Medical Education for medical student education and the Accreditation Council for Graduate Medical Education for resident education. 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 the involvement of academic societies in the assessment and modification of accrediting, licensing and certifying policies?

II. Specialization and Fragmentation

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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. Competition

The faculties of academic medical centers are involved in research and clinical service missions that require a large measure of effort. These compete for the time and energy that individual faculty members have available and, because the revenues generated from successfully competing for research grants and for caring for patients inure to the benefit of departments, institutions, and individuals, these activities have a high priority. The education of medical students is often viewed as an activity for which there is little or no financial support.

- Is an apparent lack of financial support for medical student education a deterrence to faculty involvement with this mission?

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- o Should the CAS undertake an examination of how medical student educational programs are supported and how faculty involvement in this mission can be enhanced?

IV. 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 space to augment their research and graduate student education programs.

- o Do these competitive pressures significantly detract from an institution's ability to meet its educational obligations to <u>all</u> of its students?
- o 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?

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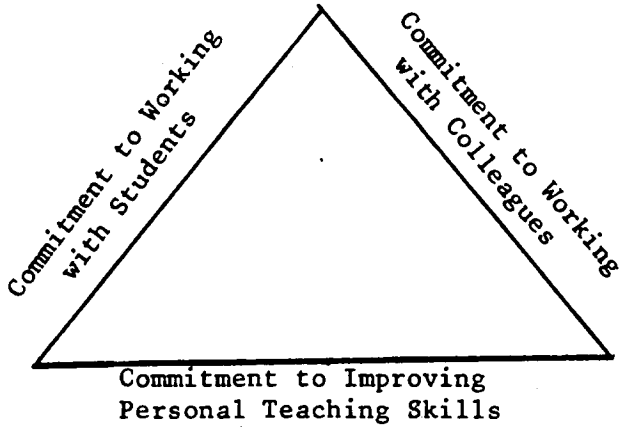
V. National Competition Among Disciplines and Specialties

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 ophthalmology, 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?

VI. 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:



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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 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 which convey that involvement with students is valued or not valued. CAS members include societies of 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?

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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 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 percent to 22 percent 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 equivalent of $76 million in FY 83. While the number of

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individual investigator (RO1) 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 percent new grantees in 1982 was the lowest percentage since 1970. The number of clinical (M.D.) investigators also continues to decline from 32 percent of the new principal investigators in 1968 to 15 percent 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 programmatic research 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

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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

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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 for capital improvements 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

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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?

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- 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

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loan forgiveness for academic careers or measures to assure a better success rate for first time grant applicants?

- o 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.

- o 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

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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 percent to 30 percent 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.

Recently, 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.

The Issues

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

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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 challenging diagnostic and management dilemmas whose referral and successful resolution 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

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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

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patient care seems to be eroding, and there is no readily identifiable alternate source of revenue.

Faculties also anticipate the possibility that the combination of pressures to limit payment for graduate medical education and the predicted surplus of physicians may lead to increasing efforts to curtail 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.

   - o Should AAMC/CAS continue to emphasize, in all appropriate contexts, the concern of academic medical centers and their faculties for quality of health care?
   - o 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.

   - o What role can CAS play in facilitating cooperation between faculties, deans and hospital executives in formulating policies related to patient care?
   - o Should CAS play a role in bringing together faculty members active in governance of their institutions' practice plans to exchange ideas and address shared concerns?

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- o Should AAMC continue its efforts to gather and disseminate information on different organizational models for faculty practice plans?
- o 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.

- o 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?

- o 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.

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- 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 formation of a Council of Societies.

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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."

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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, immediate 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,

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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 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

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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 of 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 Administrative Board meetings is spent on items in the Executive Council agenda, and most issues are resolved by consensus. Rarely have ad hoc committees composed entirely of members of a single Council been established, and the only standing committee of the CAS is the nominating committee. Conversely, Association committees are always composed of representatives from all three Councils, although the balance of representation may vary depending upon the charge to the committee.

This mode of deliberation and governance has been successful. It has promoted unity of purpose and has allowed the three major elements of

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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.

The Issues

The difficulty of allowing due deliberation and expression of a diversity of opinion while achieving consensus for rapid action has been a source of concern to each of the Councils; this tension between debate and decision, between rank democracy and representative oligarchy, characterizes

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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 lessons 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

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collaborate between disciplines and across the primary-to-tertiary care spectrum in patient care.

Strategies

I. The present structure of the Council of Academic Societies is affirmed as an effective and flexible means of assuring faculty participation in the governance of the AAMC across a broad range of disciplines and perspectives. Biannual meetings of the entire Council serve as a forum for in-depth examination of major issues of concern to the faculties and the AAMC, and an opportunity for expression of a diversity of views. The CAS Administrative Board, with its balanced representation of basic and clinical science societies, meets quarterly to debate issues of particular concern to the CAS and to provide a CAS perspective on issues facing the Executive Council of the AAMC. Since 1974, representatives from 22 different societies have filled the 29 positions which have come open on the Administrative Board.

II. Communication and cohesiveness have been highlighted as challenges for a Council which convenes biannually. Mechanisms should be sought to enchance communication between the representatives of the 76 member societies and the Administrative Board. To facilitate such communication, minutes of each Board meeting could be transmitted to the member society representatives. Another mechanism to promote communication would be to attempt to identify key long range issues which will be debated by the Administrative Board and Executive Council in the future and to provide an opportunity for individual society representatives to communicate their views to Administrative Board members.

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Although all CAS Representatives receive the AAMC Weekly Activities Report which keeps them abreast of key issues and of positions or actions taken by the AAMC, it might also prove effective to seek a feasible method for summarizing yearly the agenda of major issues debated by the CAS and soliciting representatives' recommendations about future agenda items.

III. The Administrative Board believes that ad hoc Working Groups or Task Forces of the CAS should be established on occasion to deal with specific issues in depth. Such groups with a specific charge and a membership drawn from relevant Council and Board members will be able to address specific policy issues and provide guidance to the Board in its deliberations. Members of the CAS will also continue to be active participants in AAMC-wide Task Forces. The CAS does not believe that standing committees are as effective a mechanism for dealing with diverse and rapidly changing issues as ad hoc groups which provide specific focus and flexibility.

Present examples of such efforts include the formation in July 1984 of a CAS Working Group on the GPEP Report which will deliberate the AAMC response to the Panel's Report and lead an in-depth discussion of the GPEP recommendations by the full Council at the Annual Meeting. In July, the Association also formed an AAMC Task Force on Financing Graduate Medical Education whose members include representatives from three CAS societies. Since 1980 the AAMC has convened nine Ad Hoc Committees to address a variety of policy issues including Biomedical Research and Training (1979-81), Foreign Chartered Medical Schools (1980-81),

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Maintenance of High Ethical Standards in the Conduct of Research (1981-82), and Payment for Physician Services in Teaching Hospitals (1982-83).

IV. The membership of the Council of Academic Societies has grown steadily since twenty-two chartered societies participated in its formation in 1967. An average of 2-3 new societies have joined each year. Each society may appoint two official representatives to the Council, and although societies are urged to select representatives who would be able to serve to the maximum term of eight years to provide continuity, there is substantial turnover in representation. To maximize the effectiveness of the Council an orientation packet should be prepared for new representatives to facilitate their rapid integration into Council function. The Administrative Board is also considering ways to communicate with each society about the role of the CAS and the desirability of active participation, and examining the possibility of a yearly orientation program at a Council meeting.

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 proposes 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 substantively 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

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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.

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Proposed Statement on Animal Research

Despite active participation in various efforts in support of the continued use of live animals in biomedical research and education, the AAMC has never adopted a formal statement on this issue. With the increasingly vocal public pressure to restrict or eliminate all forms of animal research, it is vitally important to the future advancement of biomedical knowledge and health care that the views of academic medicine be heard. It is appropriate that the Council of Academic Societies Administrative Board should take the lead in the formulation of an Association statement because of the involvement of CAS member societies in research and educational activities utilizing live animals.

Recommendation:

That the CAS Administrative Board approve the following statement and recommend its adoption by the Executive Council at the January 1985 meeting.

> The Association of American Medical Colleges strongly affirms the essential and irreplaceable role that research and education involving live animals has in the advance of biological knowledge, human health and animal welfare. The AAMC recognizes the responsibility of the academic medical community to ensure that the care and use of animals in laboratory research and medical education are conducted in a judicious, responsible, and humane manner. It is the Association's firm belief that any efforts to impose further restrictions on the use of live animals in biomedical and behavioral research and education would seriously compromise progress in health care and disease prevention. Therefore the Council supports the continued availability and humane use of live animals in scientific research and medical education.

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CAS DISCUSSION OF THE GPEP REPORT

The CAS Administrative Board decided at the June Board Meeting to establish a CAS Working Group to examine the Final Report of the GPEP Panel and to develop a commentary on that report which would be specific enough to enhance the likelihood of implementation of various of the report's recommendations.

The Working Group chosen in August is presently formed as a series of subcommittees assigned to the individual conclusions in the final report. The assignments are as follows:

Conclusion 1 -- Purposes of a General Professional Education -- Weldon/Kostyo

Conclusion 2 -- Baccalaureate Education -- Ginsberg/Cohen

Conclusion 3 -- Acquiring Learning Skills -- Kelly/Ganong

Conclusion 4 -- Clinical Education -- Johnson/Moody

Conclusion 5 -- Faculty Involvement -- Anderson/Wilson

Each subcommittee has been asked to discuss its assigned portion of the report at the September Board meeting and to lead Council discussion of their portion of the report at the Annual Meeting in October.

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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 followed by a 90 minute period for small group discussions. The report will be sent to all CAS representatives on September 19. Therefore, those in attendance will have had an adequate opportunity to consider the report in advance. A memorandum announcing the Sunday program had been mailed to CAS representatives and to member society presidents. Registration materials for the CAS meeting and sign-up forms for the small group will be mailed along with the copies of the final report.

Agenda for Sunday, October 28, 1984

1:30 -- 3:00 p.m. PLENARY SESSION

Speakers:

"College Preparation for Medicine"
David Alexander, D.Phil., Pomona College

"Medical School Education"
August G. Swanson, M.D., AAMC Department of Academic Affairs

Panel Discussion on GPEP Conclusions:

Philip C. Anderson, M.D.
Harold S. Ginsberg, M.D.
Joseph E. Johnson, III, M.D.
Douglas Kelly, Ph.D.
Virginia V. Weldon, M.D.

3:30 -- 5:00 p.m. WORKING GROUPS ON INDIVIDUAL GPEP CONCLUSIONS

Conclusion 1 -- Purposes of a General Professional Education
co-leaders: Weldon and Kostyo

Conclusion 2 -- Baccalaureate Education
co-leaders: Ginsberg and Cohen

Conclusion 3 -- Acquiring Learning Skills
co-leaders: Kelly and Ganong

Conclusion 4 -- Clinical Education
co-leaders: Johnson and Moody

Conclusion 5 -- Faculty Involvement
co-leaders: Anderson and Wilson

5:30 -- 7:00 p.m. CAS COCKTAIL RECEPTION

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AGENDA
CAS ADMINISTRATIVE BOARD MEMBERS
CAS ANNUAL MEETING

Sunday, October 28, 1984

Noon - 1:00 p.m. CAS Suite	Informal lunch available for Board members
1:30 - 3:00 p.m. Beverly Room	CAS Plenary Session
3:30 - 5:00 p.m. Rooms 412, 413, 414, 415, 418	Discussion Groups of GPEP
5:30 - 7:00 p.m. Belair Room	CAS Reception

Monday, October 29, 1984

Noon - 1:00 p.m. CAS Suite	Informal lunch available for Board members
1:30 - 5:00 p.m. Williford C Room	CAS Business Meeting
5:30 - 7:00 p.m. CAS Suite	Informal reception for Board members -- including new members

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