association of american medical colleges

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

WEDNESDAY, JANUARY 21, 1987
6:00 - 7:00 P.M.
JEFFERSON EAST

7:00 - 10:00 P.M.
MONROE WEST

THURSDAY, JANUARY 22, 1987
8:00 - 8:30 A.M.
JEFFERSON WEST

8:30 - 12:30 P.M.
JACKSON

one dupont circle, n.w./washington, d.c. 20036

FUTURE MEETING DATES

Administrative Board/Executive Council

April 15-16, 1987	Washington Hilton
June 17-18, 1987	Washington Hilton
September 9-10, 1987	Washington Hilton

CAS Spring Meeting

March 18-20, 1987	The Woodlands Inn Houston, Texas

AAMC Annual Meeting

November 7-12, 1987	Washington, D.C.

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Wednesday, January 21

6:00 p.m. Jefferson East	Joint Boards session w/Congressman Waxman
7:00 p.m. Monroe West	Joint Boards Reception & Dinner

Thursday, January 22

8:00 - 8:30 a.m. Jefferson West	Joint Boards Session with manpower presentation by Dr. Kennedy
8:30 - 12:30 p.m. Jackson	Administrative Boards
12:30 - 1:30 p.m. Georgetown West	Joint Boards Lunch
1:30 - 4:00 p.m. Georgetown East	Executive Council Business Meeting

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 22, 1987
8:00 a.m. - 12:30 p.m.
Jackson Room

B = Blue Executive Council
Y = Yellow CAS Agenda

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 10-11, 1986
Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members	Staff
David H. Cohen, Chairman	Christine Tuve Burris
Joe Dan Coulter	Jane B. Donovan
William F. Ganong	James B. Erdmann*
Gary W. Hunninghake	Robert Jones*
Ernst R. Jaffé	Richard Knapp*
A. Everette James, Jr.	David B. Moore
Gordon I. Kaye	Robert Petersdorf*
Jack L. Kostyo	Nancy Seline*
Frank G. Moody	John Sherman*
Virginia V. Weldon*	Elizabeth M. Short
Frank M. Yatsu	August G. Swanson*
	Kathleen Turner*

Guests

Vicki Darrow*
Donald G. Langsley
Richard Peters*

*present for part of the meeting

I. ACTION ITEMS

A. Minutes

The minutes of the June 18-19, 1986 meeting of the CAS Administrative Board were approved as submitted.

B. Membership Application

Drs. Coulter and Jaffé recommended that the Ambulatory Pediatric Association be admitted to membership in the Council of Academic Societies.

ACTION: The CAS Administrative Board voted unanimously to approve the application of the Ambulatory Pediatric Association for membership in the Council and to forward this application to the Executive Council.

C. Revision of the CAS Rules and Regulations

In January 1986 the Board recommended that the length of term for CAS representatives should be left to the discretion of the individual members' societies. This

recommendation met with approval by the full Council at the 1986 Spring Meeting. In June the Board proposed that representatives terms begin at the same time as those of Administrative Board members; i.e., following the Annual Meeting in the fall.

ACTION: The CAS Administrative Board voted unanimously to approve the following revision of the CAS Rules and Regulations with the recommendation that it be submitted to the full Council for consideration at the Annual Meeting.

Section II. Representatives

1. The Council of Academic Societies shall consist of no more than two representatives from each member Academic Society of the Association of American Medical Colleges. These representatives shall be designated by each member Society. ~~for a term of two years; provided, however, no representatives shall serve more than four (4) consecutive terms.~~ *The length of term for each representative shall be left to the discretion of each member Society. Member Societies are encouraged to appoint at least one representative to a term of sufficient length to become acquainted with the issues facing the Council. Terms for representatives shall begin and end at the time of the Association's Annual Meeting.* ~~Each member Society shall be informed one year in advance of the expiration of the term of its representatives, asking for the names of the representatives for the subsequent term.~~

The Board also discussed ways to achieve greater involvement by member societies in CAS and AAMC activities.

D. Ambulatory Care Training Act

Dr. Knapp and Ms. Seline joined the Board for a discussion of this bill. Dr. Knapp reviewed the current situation with regard to Medicare financing for graduate medical education (GME). He noted that with the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 Medicare direct GME payments will be made to hospitals on the basis of the cost per resident (based on 1984 costs adjusted by a cost-of-living index) multiplied by the number of residents. In effect, the direct GME pass-through has been replaced by capitation.

He also pointed out that the "indirect medical education" adjustment was established to compensate teaching hospitals for the unmeasurable differences (primarily related to severity of illness) in the types of patients cared for in teaching hospitals. This adjustment is made

by a proxy, which is equal to a 8.1 percent increase in DRGs for every 0.1 resident per bed in the hospital.

Dr. Knapp explained that the ambulatory care training bill would make two changes. First, it would allow hospitals to count residents in ambulatory care settings in the calculation of direct GME payments provided that hospitals incur the costs of training these residents. This raises the issue of whether the AAMC wants the payment for GME to continue through the hospital.

Second, the bill would provide bonuses for particular kinds of experiences in specific types of residency programs. Dr. Knapp noted that the AAMC position, as reflected in the Report of the Committee on Financing Graduate Medical Education, is that bonuses are all right in the context of responding to shortage areas. However, none of the specialties identified in the bill as eligible for the bonuses is a shortage area with the exception of geriatrics. There are two points related to the bonus provision. First is whether a third party (in this case the federal government) should intervene in decisions related to incentives for particular types of residency experiences. And second, incentives for one group are often accompanied by penalties for others to offset the cost of the bonuses.

The Board discussed each of the five issues listed in the Executive Council agenda. The Board agreed to pass on the issue of whether training in the ambulatory care setting should be supported through the hospital. The Board agreed with the deans that incentives for particular types of training programs should be provided on a competitive project basis.

With regard to HCFA publishing hospital specific information on Medicare education payments, Dr. Knapp noted that William Roper, the administrator of HCFA, has indicated that HCFA will publish such data. Dr. Knapp pointed out that there is a four-fold variation in payments to hospitals, which is primarily caused by the extent to which the hospital includes faculty salaries in its Medicare cost reports. He warned that some specialties that do not believe they are getting their fair share want this data published to focus attention on the distribution of these funds within the institution. He added that the AAMC cannot oppose the publication of this data.

Dr. Knapp said that the AAMC has a clear position in support of the elimination of Medicare payments for FMGs. He noted that FMGs not currently in a residency program will be required to pass the FMGEM exam, even if they have passed the ECFMG exam, which raises a legal issue related to changing the rules. In addition, FMGs would be excluded from the calculation of the resident-per-bed

ratio, which would present a hardship to institutions with large numbers of FMGs.

Dr. Knapp concluded by saying that the AAMC has been asked for its position on the bill, but suggested that the best way to approach these issues is individually, without taking a position on the bill itself.

E. NIH Centennial Celebration

The NIH will be observing the 100th anniversary of the establishment of the Hygenic Laboratory of the Marine Hospital, its predecessor agency for federal medical research, beginning October 1, 1986.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council approve a donation of $5,000 to the NIH Centennial Committee and to encourage the Executive Council to adopt a resolution in honor of the NIH Centennial.

F. AAMC Position on NBME Score Reporting

The Administrative Board was joined by Drs. Weldon, Jones, and Peters, and Ms. Darrow for a discussion of whether the Executive Council should reconsider its position in favor of reporting NBME examination scores on a pass/fail basis only to both students and medical schools. Dr. Cohen reminded the Board that this question had been a discussion item on the CAS agenda in June, but had been moved to an action item during the Executive Council meeting. Dr. Weldon said that the present discussion did not imply dissatisfaction with Executive Council's decision in June, but was intended to ensure that all of the Councils had adequate time to discuss this issue. She added that the Executive Council's discussion that afternoon would be limited to whether to reopen the issue and that the substantive discussion of the question of the pass/fail option would take place at January's Executive Council meeting.

Dr. Jones explained that this question had been generated by concerns that the present NBME score reporting was having negative effects on medical education that could be corrected by withholding the scores. Advocates of the pass/fail option want to limit the examination to its original licensing purpose.

Among the counter arguments to pass/fail score reporting are that the NBME exam is useful for student and program evaluation, that these scores are the only nationally standardized comparison of academic performance available to program directors, and that the appropriate remedy for alleged abuses is improved education on the appropriate uses of NBME scores.

It was stressed that medical school faculty write the exam questions and that the faculty have the perogative to determine institutional policies related to the use of NBME scores. It also was pointed out that the Association traditionally has let the medical schools set their own standards and policies, and that the pass/fail proposal would deny useful information to the schools on the grounds that it might be misused. The consensus of the Board was that attention should be focused on the potential for abuses of NBME scores and possible solutions rather than the mechanics of score reporting.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council reconsider its position with regard to the reporting of NBME examination scores on a pass/fail basis only.

G. California Ballot Proposal

Dr. Sherman described the proposal on the November 1986 California ballot to limit the salary and fringe benefits for California state employees to $64,000 per year. He explained that this proposal, if passed, would have a significant impact on the majority of faculty at the state medical schools in California and might set a precedent for other states. Dr. Sherman noted that a coalition of concerned individuals and organizations has been established to fight this proposal.

ACTION: The CAS Administrative Board voted unanimously to approve staff's recommendation that the Association forward a letter in support of the coalition, but decline the coalition's request for a financial contribution.

II. DISCUSSION ITEMS

A. Discussion with Dr. Petersdorf

Dr. Petersdorf met with the Board to discuss some of his initial perceptions upon returning to the AAMC. He noted that the CAS consists of representatives from societies that do not have as their primary aim the representation of faculty in the AAMC, but that this system works because the representatives can act much more independently than if they were elected from the faculties.

Dr. Petersdorf discussed the possibility of housestaff and graduate students and post-doctoral fellows being represented in the AAMC, with housestaff attached to the COTH and the graduate students and post-doctoral fellows to the CAS in the same manner that the OSR is attached to the COD.

He said that there may be some reorganizations of staff made after careful consideration of the present

structure. The constituents will be surveyed as to what the AAMC does well and what it could do better.

Focusing on manpower, Dr. Petersdorf said that the AAMC must develop a rational policy that is more responsive to societal needs. He added that the AAMC is a source of tremendous data, which he hopes will be used to effect change. He urged that the AAMC should not become known as a "staunch defender of the status quo."

Finally, he said that he hoped to develop a strategic plan for the next 5 years, recognizing the necessity for the AAMC to be somewhat reactive because of the uncertainty of future legislative activities.

B. HHS Policy on Indirect Costs

Dr. Jaffee raised the issue of the HHS proposal -- announced in the August 13 Federal Register -- to provide initial review groups (study sections) with the applicant institution's indirect costs on each grant application. It was pointed out that for the past several years study sections have been instructed to look at the direct costs of research proposals, but that this is done to determine if the budget is appropriate to carry out the proposed research, not to place a priority on the proposal based on budgetary considerations.

Dr. Short said that the NSF looks at the total cost of its research applications, including the indirect costs. The HHS proposal was partially in response to recommendations by both the Office of Science and Technology Policy and the White House Science Council that the entire federal government adopt the NSF system. Concerns also have been expressed with the rise in indirect costs as a percentage of total costs on NIH grants.

Dr. Short noted that this proposal has a 60-day comment period and that the Association is considering whether or not to comment. The Board agreed that a key issue is the threat that this proposal poses to the peer review process, which is intended to evaluate scientific merit. The consensus of the Board was that the AAMC should protest this proposal.

III. INFORMATION ITEMS

A. Program for 1986 CAS Annual Meeting

The Board reviewed the schedule for the Annual Meeting, including the Special General Session on the Transition, which was scheduled for Sunday afternoon.

B. Format for 1987 CAS Spring Meeting

The Board discussed possible keynote speakers for the Spring Meeting, including Senator Lloyd Bentsen, H. Ross Perot, and Representative Jim Wright.

Dr. Short explained that Thursday's plenary would consist of an indepth Council discussion of one or two Key issues. It was the consensus of the Board that the declining applicant pool for both M.D.s and Ph.D.s would be a major topic of interest.

C. AAMC ad hoc Committee on Strategies for Promotion of Academic Medical Centers

Dr. Short reviewed the membership of this committee, which was appointed in June to explore the role of the AAMC in assisting its constituent academic medical centers in the competitive health care market.

D. Flexner and Research Awards

The 1986 Abraham Flexner Award for Distinguished Service to Medical Education will be given to David E. Rodgers, M.D., president of the Robert Wood John Foundation.

The AAMC Award for Distinguished Research in the Biomedical Sciences will be given to Paul C. Lauterbur, Ph.D., professor of medical information science at the University of Illinois College of Medicine.

E. VA Cardiac Surgery

The Board discussed the decision to close the cardiac surgery programs at a number of VA hospitals. The Board was informed that the COD Administrative Board was discussing this issue with John Gronvall, the acting VA medical director. It was pointed out that this decision is part of a larger question: the trend toward regionalization of complex, highly expensive medical and surgical procedures that may require a certain volume of patients to ensure quality. The Board agreed that the effects of this trend on the quality of medical education should be followed closely.

MEMBERSHIP APPLICATION:

ASSOCIATION OF ACADEMIC CHAIRMEN
OF PLASTIC SURGERY

The application of the Association of Academic Chairmen of Plastic Surgery for membership in the CAS was assigned to Drs. Coulter and Hunninghake for review. The membership of this society is limited to the directors and acting directors of residency training programs in plastic surgery; thus all 189 members hold faculty appointments. At present, the CAS has three plastic surgery societies: the American Association of Plastic Surgeons, the Plastic Surgery Education Foundation, and the Plastic Surgery Research Council.

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: American Association of Chairmen of Plastic Surgery

MAILING ADDRESS: %Stephen H. Miller, M.D.; Oregon Health Science University; Plastic Surgery; 3181 S.W. Sam Jackson Park Road; Portland, OR 972

PURPOSE: To promote education in plastic surgery and to benefit plastic surgery programs in the United States and Canada.

MEMBERSHIP CRITERIA: Voting Membership must be the Director or Acting Director of a residency training program. Associate Membership: Individual interested in teaching of plastic surgery at the resident level.

NUMBER OF MEMBERS: 189

NUMBER OF FACULTY MEMBERS: 189, full-time and clinical faculty

DATE ORGANIZED: 4/28/85

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

accepted 10/12/85 1. Constitution & Bylaws

Minutes from meetings on----
4/28/85
10/12/85 and 5/4/86 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?

✓ 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.

[signature] Pres 5/14/84
(Completed by - please sign)
[signature] Secy-Treas 5/27/84

_____
(Date)

APPOINTMENT OF 1987 CAS NOMINATING COMMITTEE

Section V.1 of the CAS Rules and Regulations reads as follows:

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

On the following pages is a list of all CAS representatives from which the Board must choose at least three basic scientists and at least three clinical scientists to serve on the CAS Nominating Committee. The Board also must select a chairman for the Nominating Committee. Traditionally, the Chairman and Chairman-Elect of the CAS are members of the Nominating Committee. Several Alternates should also be selected. The Committee will meet by conference call some time in May or early June to nominate a clinical scientist to be Chairman-Elect of the CAS. The Committee also will develop a slate of nominees to fill three positions on the Board.

The 1983-1986 CAS Nominating Committees are listed below:

1983

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

1984

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

1985

David H. Cohen, Ph.D., Chairman
John M. Bissonnette, M.D.
William R. Drucker, M.D.
George A. Hedge, Ph.D.
William P. Jollie, Ph.D.
Louis M. Sherwood, M.D.
Virginia V. Weldon, M.D.

1986

Frank G. Moody, M.D., Chairman
JoAnne Brasel, M.D.
David H. Cohen, Ph.D.
Rolla B. Hill, M.D.
Mary Lou Pardue, M.D.
Jerry Wiener, M.D.
Nicholas Zervas, M.D.

CAS REPRESENTATIVES

BASIC SCIENCES

ANATOMY
American Association of Anatomists
John V. Basmajian, M.D.
William P. Jollie, Ph.D.
American Society for Cell Biology
Mary Lou Pardue, Ph.D.
Ms. Dorothea C. Wilson
Association of Anatomy Chairmen
Douglas E. Kelly, Ph.D.
Gordon I. Kaye, Ph.D.

BEHAVIORAL SCIENCE
Association for the Behavioral Sciences and Medical Education
Beverley Rowley, Ph.D.
Shirley Nickols Fahey, Ph.D.

BIOCHEMISTRY
American Society of Biological Chemists
William J. Whelan, D.Sc.
Robert D. Wells, Ph.D.
Association of Medical School Departments of Biochemistry
Thomas E. Smith, Ph.D.

GENETICS
American Society of Human Genetics
Jessica G. Davis, M.D.

MICROBIOLOGY
Association of Medical School Microbiology Chairmen
Kenneth I. Berns, M.D., Ph.D.

NEUROSCIENCE
Society for Neuroscience
David H. Cohen, Ph.D.
Joe Dan Coulter, Ph.D.

PATHOLOGY
* American Association of Pathologists

Association of Pathology Chairmen
Aubrey J. Hough, M.D.
Vivian W. Pinn-Wiggins, M.D.
Academy of Clinical Lab Physicians and Scientists
Ronald J. Elin, M.D., Ph.D.
S. Thomas Shaw, M.D.

PHARMACOLOGY
American College of Neuropsychopharmacology
Arnold Friedhoff, M.D.
Oakley Ray, Ph.D.
American Society for Clinical Pharmacology and Therapeutics
Carl C. Peck, M.D.

* New

William Z. Potter, M.D., Ph.D.
American Society for Pharmacology and Experimental Therapeutics
Lewis Aronow, Ph.D.
William L. West, Ph.D.
Association for Medical School Pharmacology
Paul C. Bianchi, Ph.D.
James W. Fisher, Ph.D.

PHYSIOLOGY
American Physiological Society
Jack Kostyo, Ph.D.
George Hedge, Ph.D.
Association of Chairmen of Departments of Physiology
William F. Ganong, M.D.
Stanley Schultz, M.D.

PREVENTIVE MEDICINE
Association of Teachers of Preventive Medicine
David L. Rabin, M.D.
Jay Noren, M.D.

CLINICAL SCIENCES

ANESTHESIOLOGY

Association of University Anesthetists
- Milton H. Alper, M.D.
- C. Philip Larson, Jr., M.D.

Society of Academic Anesthesia Chairmen
- S. Craighead Alexander, M.D.
- Robert M. Epstein, M.D.

CRITICAL CARE

Society of Critical Care Medicine
- Solomon G. Hershey, M.D.

DERMATOLOGY

Association of Professors of Dermatology
- Philip C. Anderson, M.D.
- Thomas B. Fitzpatrick, M.D.

EMERGENCY MEDICINE

Society of Teachers of Emergency Medicine
- Glenn C. Hamilton, M.D.
- Richard M. Nowak, M.D.

University Association for Emergency Medicine
- Thomas Stair, M.D.
- Michael Callaham, M.D.

FAMILY MEDICINE

Association of Departments of Family Medicine
- Thornton Bryan, M.D.
- Harry Mayhew, M.D.

Society of Teachers of Family Medicine
- Jack M. Colwill, M.D.
- Christian N. Ramsey, Jr., M.D.

GENERAL SURGERY

American Association for the Surgery of Trauma
- William R. Drucker, M.D.
- Donald S. Gann, M.D.

American Surgical Association
- Walter Lawrence, M.D.
- Judson Randolph, M.D.

Association for Academic Surgery
- John R. Clarke, M.D.

* Association for Surgical Education
- A. L. Imbembo, M.D.
- Norman Snow, M.D.

Society for Surgery of the Alimentary Tract
- Lawrence Way, M.D.
- Henry A. Pitt, M.D.

Society of Surgical Chairmen
- Frank G. Moody, M.D.

Society of University Surgeons
- Christopher C. Baker, M.D.
- Dana K. Andersen, M.D.

Surgical Infection Society

* New

John F. Burke, M.D.
Roger W. Yurt, M.D.

INTERNAL MEDICINE
American College of Physicians
Marvin Turck, M.D.
John A. Spittell, Jr., M.D.
American Federation for Clinical Research
Gary M. Hunninghake, M.D.
David Hathaway, M.D.
American Gastroenterological Association
John T. Farrar, M.D.
Irwin H. Rosenberg, M.D.
American Society for Clinical Investigation
Robert J. Lefkowitz, M.D.
Thomas P. Stossel, M.D.
American Society of Hematology
Richard A. Cooper, M.D.
Ernst R. Jaffe', M.D.
Association of American Physicians
Leighton E. Cluff, M.D.
Alfred J. Bollett, M.D.
Association of Professors of Medicine
Norman G. Levinsky, M.D.
Harold J. Fallon, M.D.
Association of Program Directors in Internal Medicine
James J. Leonard, M.D.
Richard E. Rieselbach, M.D.
Central Society for Clinical Research
Murray L. Levin, M.D.

MULTISPECIALTY
American Academy of Allergy and Immunology
Paul Van Arsdel, M.D.
American Association for the Study of Liver Diseases
David Van Thiel, M.D.
Paul D. Berk, M.D.
American Geriatrics Society
Knight Steel, M.D.
L. Gregory Pawlson, M.D.
American Society for Clinical Nutrition
George A. Bray, M.D.
Edward S. Horton, M.D.
Endocrine Society
Jo Anne Brasel, M.D.
Virginia V. Weldon, M.D.
Society for Health and Human Values
Christine K. Cassel, M.D.
Rita Charon, M.D.

NEUROLOGY
American Academy of Neurology
Jerry G. Chutkow, M.D.
Rosalie A. Burns, M.D.
American Neurological Association
Kenneth P. Johnson, M.D.

Frank M. Yatsu, M.D.
Association of University Professors of Neurology
Donald Silberberg, M.D.
Mark Dyken, M.D.
Child Neurology Society
Gwendolyn R. Hogan, M.D.
Samuel Shelburne, M.D.

NEUROSURGERY
American Association of Neurological Surgeons
Nicholas Zervas, M.D.
Robert Grossman, M.D.

OBSTETRICS AND GYNECOLOGY
American College of Obstetricians and Gynecologists
Harrison C. Visscher, M.D.
Harry S. Jonas, M.D.
Association of Professors of Gynecology and Obstetrics
Douglas R. Knab, M.D.
Joseph C. Scott, M.D.
Society for Gynecologic Investigation
John M. Bissonnette, M.D.
Edward E. Wallach, M.D.

OPHTHALMOLOGY
American Academy of Ophthalmology
Robert D. Reinecke, M.D.
Joel G. Sacks, M.D.
Association of University Professors of Ophthalmology
Claude L. Cowan, Jr., M.D.
Michael A. Lemp, M.D.

ORTHOPAEDICS
American Academy of Orthopaedic Surgeons
Frank C. Wilson, Jr., M.D.
Frederick A. Matsen, III, M.D.
American Orthopaedic Association
Robert B. Greer, M.D.
George E. Omer, Jr, M.D.
Association of Orthopaedic Chairmen
Gerald Laros, M.D.
Wilton H. Bunch, M.D., Ph.D.

OTOLARYNGOLOGY
Association of Academic Departments of Otolaryngology
Robert I. Kohut, M.D.
Warren Y. Adkins, M.D.
Society of University Otolaryngologists - Head and Neck Surgeons
Jerome Goldstein, M.D.
Lee A. Harker, M.D.

PEDIATRICS
* Ambulatory Pediatric Association
Jay E. Berkelhamer, M.D.
Ruth Stein, M.D.
American Pediatric Society

* New

Myron Genel, M.D.
Charles A. Alford, M.D.
Association of Medical School Pediatric Department Chairmen
Robert M. Blizzard, M.D.
Thomas K. Oliver, M.D.
Society for Pediatric Research
Lawrence A. Boxer, M.D.
William F. Balistreri, M.D.

PHYSICAL MEDICINE AND REHABILITATION
American Academy of Physical Medicine and Rehabilitation
B. Stanley Cohen, M.D.
Arthur E. Grant, M.D.
Association of Academic Physiatrists
John F. Ditunno, M.D.
Ernest W. Johnson, M.D.

PLASTIC SURGERY
American Association of Plastic Surgeons
Hal G. Bingham, M.D.
Charles E. Horton, M.D.
Plastic Surgery Educational Foundation
R. Barrett Noone, M.D.
Paul N. Manson, M.D.
Plastic Surgery Research Council
Jane A. Petro, M.D.
David J. Smith, Jr., M.D.

PSYCHIATRY
American Association of Chairmen of Departments of Psychiatry
Robert L. Leon, M.D.
Jerry M. Wiener, M.D.
American Association of Directors of Psychiatric Residency Training
Stefan Stein, M.D.
William H. Sledge, M.D.
American College of Psychiatrists
Robert L. Williams, M.D.
Robert O. Pasnau, M.D.
American Psychiatric Association
Herbert Pardes, M.D.
Daniel X. Freedman, M.D.
Association for Academic Psychiatry
Carolyn Robinowitz, M.D.
Thomas G. Webster, M.D.
Association of Directors of Medical Student Education in Psychiatry
Chase P. Kimball, M.D.
Beth Ann Brooks, M.D.

RADIOLOGY
Association of University Radiologists
Paul J. Friedman, M.D.
A. Everette James, Jr., M.D.
Society of Chairmen of Academic Radiology Departments

Joshua A. Becker, M.D.
James H. Scatliff, M.D.

THORACIC SURGERY
American Association for Thoracic Surgery
Thomas C. King, M.D.
Judson G. Randolph, M.D.
Thoracic Surgery Directors Association
Hermes C. Grillo, M.D.
Benson R. Wilcox, M.D.

UROLOGY
Society of University Urologists
David G. McLeod, M.D.
William L. Parry, M.D.

COMMENTARY OF THE COUNCIL OF ACADEMIC SOCIETIES ON THE PRELIMINARY REPORT OF THE AD HOC TRANSITION TASK FORCE

Discussion of the preliminary report at the September Administrative Board meeting and October Council business meeting was thorough and thoughtful. Council members benefited in their deliberations from prior discussions within the leadership of a number of the academic disciplines and by the comments offered in the Special General Session at the Annual Meeting. Discussion focused on the Report's recommendations in six broad areas. In some there was consensus, in others, modifications were suggested and finally, several areas were delineated in which the Council desired further discussion by all concerned parties before any final recommendations were made.

1. Institutional Responsibility

The Council agreed that collective responsibility of all participants in GME was desirable and would be beneficial in a wider context than just overseeing compliance with traffic rules or paperwork for resident selection. As GME faces increasing pressures from limited resources and potential manpower constraints, some process of collective governance of GME should evolve. An academic governance mechanism which ensures representation of all disciplines involved in GME as well as institutional representatives could best address such key issues as resource allocation, integration of training sites and quality control as well as adherence to rules for resident selection.

With regard to processes for resident selection, the Council was concerned that as presently phrased, the report appeared to suggest replacement of the current system of disciplinary-based resident selection procedures with a welter of individual institutionally-based procedures still lacking in national coordination. To the extent that a coordinated national selection system could be established which would meet the needs of the individual GME disciplines, schools and students (see Section 5), institutional as well as disciplinary responsibility for collective compliance would be useful. Council members, largely based in academic-intensive institutions with integrated multihospital programs within a discipline and an excess of candidates to resident positions, did not see the virtue of collectively processing large numbers of applications for separate disciplines centrally. The merits of integrated selection of candidates within a discipline across multiple affiliated hospitals, of multispecialty integration of candidate selection for transitional year internships, and of better integration of PGY1 selection with PGY2 or later specialty residency programs were affirmed.

2. Institutional accreditation

The Council felt that institutional adherence to the ACGME General Requirements for Approved Residencies was desirable and supported the notion that an appropriate system for academic governance of GME would enhance institutional compliance with these principles. While enforcement of the General Essentials would improve the quality of the GME program in some institutions, Council members expressed doubt that creating a process

for institutional accreditation of GME was germane to addressing problems in the Transition.

While not intrinsic to solving problems at the Transition, this section deserved separate debate on its own merits. The recommendation of separate ACGME accreditation of each institution was addressed. Some expressed support for an ACGME review separate from RRC program accreditation, but were concerned what relationship this would bear to the responsibilities and prerogatives of the individual RRCs. The notion was advanced that ACGME accreditation, rather than being "binding upon" each RRC, should be a "necessary but not sufficient condition "for approval of a residency." The relationship to LCME accreditation was unclear.Concern was expressed that a separate process would be topheavy in settings with few, small programs. The apparent reluctance of ACGME to assume this burden, as expressed by Dr. Riddick at the Special Session, was noted. Others saw merit in the concept of incorporation of compliance with the General Essentials into each RRC accreditation, while acknowledging that this method did not provide a unified judgment on which to base institutional responsibility for identifying resources to meet accreditation standards. In short, the Council recomended that further exploration and dialogue between all parties to GME was needed before this issue was ripe for specific recommendations.

3. Medical School Problems/Quality of Clinical Education

The Council concurred with the intent of recommendations in this section to make it the responsibility of each medical school and

its faculty to scrutinize closely the clinical curriculum of its medical students and take the suggested steps to insure the quality and educational sequence of clerkships and electives. This section could be strengthened by a recommendation to develop/strengthen the advising system in each school to assist students in elective selection consistent with their general education and career plans. The recommendation to complete the core clerkship sequence before any away electives generated some concern. The concept was supported, but more flexible wording was recommended to avoid the appearance of establishing a single national curriculum and to avoid logistical problems in some schools. Finally, some members urged a better integration of the core clinical curriculum and specialty teaching; specialties should participate in multi-disciplinary program teaching as part of general professional education and not be relegated only to career-related electives.

4. Selection Criteria Problems

The Council agreed that written evaluations of students should be strengthened and accurately portray the student's characteristics and abilities. It was felt that faculty letters and "Chairman's letters" as well as Dean's letters should follow this practice and that such letters should be informative enough to permit residency candidates to be evaluated without on-site performance. The Council felt strongly that where standardized, nationally referenced test scores were available, they should not be withheld and that all aspects of student performance, including basic

science knowledge, were germane to resident selection. The problem of "audition electives" should be handled by recommending that students not take multiple electives, or no more than one visiting elective in a discipline.

5. Procedural Problems

This section, which deals with the actual procedures for matching medical students to residency positions was the subject of much thoughtful interchange. The Council appreciated the CAS Board commentary on this section and their own comments both at the Special Session and the CAS Business Meeting reflected the sense that an avenue has been opened for a constructive dialogue during which mutual concerns can be shared and from which may eventually come proposals for selection of residents from the medical school senior class which better integrate and meet the needs of all parties.

Council members overwhelmingly agreed that shortening the NRMP match process and moving a condensed application-to-match sequence to a later time in the senior year would be very useful and should be recommended. They felt that this goal could be pursued vigorously even under the present system of separate matches for PGY2 programs. If a truncated NRMP timetable were achieved, the application process for all programs could begin with a later release of medical school letters, and a better evaluation of students. Some concern was expressed that an intern match date of April 1 was so late as to be a burden to the family and career plans of student's partners.

The problem in the current selection processes was clearly identified as that of coordinating PGY2 specialty resident selection with PGY1 assignments. All specialties selecting from graduating students for PGY2 or later residency positions were willing to continue discussions aimed at achieving a better integration of these selection processes. A range of issues was identified which could form the agenda for such discussions:

a) the problems of different programs within a discipline awarding residency positions at different times,

b) the desire of many PGY2 programs to have PGY1 positions in other disciplines at their disposal so as to provide program continuity for their residents,

c) the possibility that a biphasic match best meets the needs of applicants and programs and should be continued with better coordination,

d) the concern that any attempt to match some students before others creates a psychic problem of herd stampede,

e) the concern that specialties now matching through small, separate computer programs were vulnerable to mechanical or personnel failures,

f) the desire to simplify the application and interview process for students and programs with PGY1/PGY2 needs,

g) the value of having all student matching under the aegis of one management for ease of administration and central data collection,

h) the growing belief that an integrated system, whether it required one or more match sequences, could be derived if the needs of programs and students were well understood,

i) the possibility that if an integrated system could be developed, all programs within a discipline could be constrained to participate by making participation part of the General Essentials requirements.

The CAS/AAMC was seen as a possible convener of such deliberations which should take place before any more specific recommendations about the role of NRMP or the use of match(es) were forthcoming.

Lastly, a universal application form was felt to be useful. The form should be periodically reviewed by program directors so that it best meets their needs and minimizes the need for supplementary forms.

6. Implementation

The recommendation to convene a group representing all parties involved in the transition under AAMC auspices was supported. This overview group was seen as different from the working group on the match process suggested under Section 5.

THE TEACHING OF CLINICAL PHARMACOLOGY

Last fall Richard Weinshilboum, president of the American Society for Clinical Pharmacology and Therapeutics (ASCPT), approached staff with a request on behalf of ASCPT and the American Society for Pharmacology and Experimental Therapeutics for assistance in initiating a discussion within the AAMC related to the status of education in clinical pharmacology and therapeutics. As described in the attached summary, ASCPT has been engaged during the past year in a consideration of various strategies to enhance the format and content of instruction in clinical pharmacology and therapeutics during the third and fourth years of medical school. They are now at the stage of attempting to implement these strategies within the medical school curriculum.

The generic issue underlying the ASCPT's request is how educational issues such as this should be addressed within the CAS. Is the most effective and efficient method of disseminating information and soliciting discussion on such issues through a presentation to the Council at the biannual business meetings, as was done by the Association of Chairmen of Pathology last fall?

RECOMMENDATION

The Administrative Board should discuss whether the CAS should address educational issues related to individual disciplines such as those raised by the ASCPT and the Association of Pathology Chairmen and, if so, how.

Results of 1985 Survey of Medical School Instruction in Clinical Pharmacology, and Summary of Discussion from January 1986 Dartmouth Workshop on Teaching Clinical Pharmacology to Medical Students

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The American Society for Clinical Pharmacology and Therapeutics (ASCPT), through its Medical Education Committee, has traditionally been active in promoting the teaching of clinical pharmacology, primarily in the spheres of educating postdoctoral fellows and enhancing the continuing medical education of practicing physicians. During the past year, the leadership of the Society proposed several actions which increased the Society's activities in the area of undergraduate medical education. After the March 1985 meeting, funds were approved to sponsor a survey of current teaching in clinical pharmacology at U.S. medical schools. That survey was conducted in October 1985. Dr. Lowenthal, immediate past president of the ASCPT, proposed holding a winter workshop to discuss teaching clinical pharmacology to medical students. That workshop was held at Dartmouth Medical School in January 1986. During the March 1986 meeting, the Society sponsored both a poster session and a symposium concerning the teaching of clinical pharmacology to medical students.

In this brief report, I will provide a brief overview of past efforts to teach clinical pharmacology to medical students; present the results of the survey on current teaching of clinical pharmacology at U.S. medical schools; and summarize the discussions and tentative conclusions of the workshop participants.

PAST TEACHING EFFORTS

That clinical pharmacologists must teach students at all levels "the basic concepts of an approach to rational therapeutics" is not a new concept (1). The preface from an early American textbook in clinical pharmacology specifically stated that the book was written to help medical

students understand a general approach to rational drug therapy, since almost all teaching in this area still occurred in a "hand-me-down" fashion (2). Furthermore, it was recognized that the discipline of clinical pharmacology required knowledge of, and prior training in, both basic medical pharmacology and basic clinical medicine.

In 1980, the Association for Medical School Pharmacology surveyed all 110 US medical schools concerning their clinical pharmacology programs (3). Of the 81 schools which responded, only 36 could identify clinical pharmacology as a separate teaching entity in the third or fourth years of the medical school curriculum. Teaching was performed in a variety of formats, and was either elective or required. Topics varied from subspecialty therapeutics (e.g. treatment of congestive heart failure) to concepts in general clinical pharmacology (e.g. adverse reactions to drugs). The next year, Peck and Halkin described an 18 hour course in therapeutic decision making for second year medical students, and documented both the intensive faculty time required, and the difficulty of teaching clinical pharmacology to second year students because of their unfamiliarity with clinical problems (4). Later, an editorial stressed that the best educator in clinical pharmacology would probably be "a physician, preferably one working in the classrooms and at the bedsides of university-based medical-student and house-staff training programs"(5).

In 1984, Spector and Roberts proposed a longitudinal plan for physician education about drug therapy, beginning in the second year of medical school and extending through the physician's professional life (6). The two parts of the plan which related to medical schools included continuing the basic pharmacology course in the second year, and introducing a required course in basic principles of clinical pharmacology

to be taught in the fourth year. Later that year, Ferguson and Vlasses described a four-week elective course which they offered to their fourth-year students, which included not only didactic lectures, but also case discussions, student presentations, and written case evaluations (7).

That same year, the Association of American Medical Colleges published the Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine, the "GPEP Report" (8). The report stressed that all students required a common foundation of knowledge, skills, values, and attitudes, regardless of their intended areas of specialization. Also, the report stressed the importance of integrating basic science and clinical education. While the report made many other recommendations, both of these concepts have direct application to undergraduate medical education in clinical pharmacology.

Most recently, Reidenberg discussed how the discipline of clinical pharmacology had moved two broad themes--the use of the scientific method to study the effects of drugs in man, and the individualization of drug therapy--into the mainstream of medicine. One of the roles of the clinical pharmacologist remained to teach about these two themes (9).

During the March 1986 meeting, the ASCPT sponsored both a poster session and a symposium concerning undergraduate medical education in clinical pharmacology. Thus, 1986 seems to be an appropriate year to reassess our current programs for teaching clinical pharmacology to medical students, and to summarize discussions on possible future endeavors.

SURVEY OF CURRENT TEACHING IN CLINICAL PHARMACOLOGY

In October 1985, a four-page survey was sent to all 127 American

medical schools. The survey was sent to the director of the clinical pharmacology program when such a person could be identified (10). When no such person was identifed, the survey was sent to the Dean of Academic Affairs at each medical school, with an appropriate cover letter. A second mailing was sent out 1 month later to all schools which had not responded. Eighty-eight schools responded (69.3% response rate). In the discussion below, the percentages of all responses to each question are listed. Most questions were answered by more than 60 of the 88 responders.

Basic pharmacology instruction: The average class size was 124 students. All schools offered a required course in basic medical pharmacology, usually taught in the second year (96%), but occasionally taught in the first year (4%). The average number of hours in this course was 114; a portion of these hours was spent on topics related to clinical pharmacology at 84% of the schools.

Required teaching in clinical pharmacology: Only 14% of schools offered required courses in clinical pharmacology; of those which did not, 87% taught material related to clinical pharmacology within other required courses. On average, 18.4 hours of required instruction in topics related to clinical pahrmacology were given before graduation. In years one through four, the time was apportioned as 0.4, 10.5, 3.1, and 3.8 hours respectively.

Of this average figure of 18.4 hours instruction, 12.0 hours were in the form of lectures, and 6.3 hours in conferences or seminars. These required hours were taught by the Department of Pharmacology (80%), Medicine (7%), or other (14%). The actual teaching was performed by PhD's in Pharmacology (32%), MD's in Pharmacology (36%), MD's in clinical departments (30%), or others (3%).

Elective courses in clinical pharmacology: Of the schools which responded, 60% offered an elective course in clinical pharmacology. The format was either classroom instruction (24%), a clinical rotation (46%), or other (30%). The average length of the elective course was either 55 hours or 3.8 weeks. The average number of students who took the elective during the previous year was 22 (average graduating class size was 124).

General clinical pharmacology: Topics which represented 17 areas of general "core" material in clinical pharmacology were included on the survey. Each responder was asked to state whether he thought these topics should be required and taught in an ideal curriculum, and whether present coverage in his medical school was adequate. These topics and results are listed in Table 1. Responders usually agreed (mean 92.3%) that these topics should be required and taught in an ideal curriculum. However, there was considerably less confidence (mean 57.4%) that such topics were being adequately covered in the present medical school curricula.

Specific areas of therapeutics: The survey also inquired about whether medical schools should teach (somewhere in the curriculum) material concerning therapeutics in 16 specific disease areas (see Table 2). Again, most of the responders (mean 93.6%) felt that this information should be taught in an ideal curriculum. Some responders were unsure whether this information was being adequately covered at present. Many of those who expressed an opinion felt that this material was not being adequately covered in their medical schools.

General conclusions: Several questions at the end of the survey were designed to explore future directions in teaching clinical pharmacology. Of those who responded, 87% felt that an ideal curriculum should include a required, separate course in clinical pharmacology. Those who favored

this idea felt that the course should be held in the third year (22%), the fourth year (64%), or either the third or fourth year (12%). Only 1% felt the course should be held in the second year; none felt that it should be held in the first year. Regarding course format, 54% felt that such a course should be classroom oriented; 19% felt it should be a clinical rotation; and 26% felt it should have another format, usually a combination of the two above. Of the medical schools which do not currently have a required course, only 11% indicated plans to implement such a course in the next few years. Finally, 62% of the schools which responded indicated that they presently had a section or division of clinical pharmacology, although several schools indicated that the section was vacant at present.

WORKSHOP ON TEACHING CLINICAL PHARMACOLOGY

In January 1986, at the suggestion of Dr. Lowenthal, an informal workshop was held at Dartmouth Medical School to discuss various issues related to teaching clinical pharmacology to medical students. Participants included Carl Peck (Uniformed Services University of the Health Sciences), Terrance Blaschke (Stanford University Medical Center), Edward Sellers (Faculty of Medicine, University of Toronto), Edward Carr (State University of New York at Buffalo), Richard Mamelok (Stanford University Medical Center), Richard Weinshilboum (Mayo Clinic), Alexander Shepherd (Universlsity of Texas Health Sciences Center, San Antonio), David Lowenthal (Hahnemann University), and David Nierenberg (Dartmouth Medical School). The discussions were continued at a second informal meeting held during the March 1986 ASCPT meeting. A number of questions were addressed, and a summary of the consensus developed about these points follows.

Past teaching practices: A review of past editions of several commonly used textbooks of both medicine and basic pharmacology revealed little emphasis on principles of rational therapeutics. Textbooks could have a very important role in this area, since most medical schools still do not have sections of clinical pharmacology, and those that do may have only one or two members within the section. Recent editions of textbooks of medicine (11) and pharmacology (12) have devoted considerably more attention to "core" material in clinical pharmacology. In addition, several new textbooks devoted to clinical pharmacology have recently been published (13,14).

Concern has been expressed among faculty members in clinical pharmacology that if much time is spent teaching medical students, this will harm career advancement, which is usually based predominantly upon academic achievement as measured by receipt of grants and publication in peer-reviewed journals. In any case, only 14% of medical schools offer required courses in clinical pharmacology; medical students receive on average only 18.4 hours of instruction in areas related to clinical pharmacology before graduation; and most of this instruction is done by basic scientists from Pharmacology departments during the second year. Thus most students are not exposed to teaching by clinician-pharmacologists, and are probably not required or urged to read relevant material in medicine, pharmacology, or clinical pharmacology textbooks.

Core information in clinical pharmacology: The group reached a consensus that there was a body of knowledge within the discipline of clinical pharmacology which could be considered "core" information, and which should be taught at every American medical shcool. This information

included all 17 of the topics listed in the survey (see Table 1). Other topics which were felt to represent "core" information included: 1)Principles of therapeutic decision making; 2)Generic drug use and economics of drug use and development; 3)Influences upon physician prescribing behavior; 4)Medicolegal issues relating to rational prescribing (e.g. informed consent, prescribing drugs for non-approved indications, restricted hospital formularies, etc.); and, 5)Use and abuse of over-the-counter drugs. This list of "core" topics included all of the topics proposed by Spector and Roberts in their paper (6). All of these topics are primarily related to the development of a rational approach to therapeutics, rather than to specific areas of therapeutics.

There was recognition that many of these same topics are considered necessary "core" topics by chairmen of medical school pharmacology departments. That group identified the minimum knowledge base in pharmacology which every student trained as an undifferentiated physician should have at the time of graduation from medical school (15). In their proposed "ideal" course of 133 hours, fully 18 hours of classes were proposed in the above areas. In addition, the 87 medical schools in that survey reported that their current second year pharmacology courses (averaging 89.5 hours of class time) included 13 hours in areas directly related to clincial pharmacology. Thus many of the content areas identifed at the workshop as representing "core" clinical pharmacology material had already been identifed by either clinical pharmacologists (6) or by Pharmacology Department Chairmen in medical schools (15).

The workshop participants discussed whether topics in specific areas of therapeutics (such as a rational approach to the treatment of hypertension, or a rational approach to the treatment of sepsis) should be

taught. The group reached a consensus that such teaching was essential in medical school, but that it could be done on clinical rotations in medicine, surgery, pediatrics, etc. While such topics did not appear to be part of an essential "core" curriculum in clinical pharmacology, their incorporation into such a course would certainly strengthen the course. However, their addition would also add hours to a course which might have difficulty obtaining those hours. Ultimately, if such topics were included in a required course, they should be used primarily to reinforce the basic therapeutic principles outlined in the core lectures, rather than attempting to describe detailed therapeutic options in a variety of specific diseases.

Timing of instruction: The participants of the workshop generally agreed that the best time to teach clinical pharmacology to medical students is in the fourth year. At that time, students will have had their second year course in basic pharmacology, and have completed required clincial rotations in their third year. They are thus prepared to tackle the more difficult issues involved in individualizing therapy. This conclusion was in agreement with the results of the survey previously mentioned.

The workshop group also recognized the difficulties of teaching such a required course in the fourth year. This is traditionally a year of electives for medical students; thus most students are scattered over many hospitals or even different states. It might be easier to develop a required course in the third year (in conjunction with medicine), or in the second year (as part of the basic pharmacology course). These alternatives were felt to be better than no teaching in clinical pharmacology, but were also recognized as suboptimal. Teaching in the

third year would superimpose even more material onto an already very crowded and compressed clinical experience. Teaching clinical pharmacology in the second year was felt to be suboptimal because those students would have little or no direct knowledge of clinical medicine, and therefore could not fully comprehend the material, as previously noted by others (4). Thus, in an ideal curriculum, most participants felt that a medical school would require all fourth-year students to return to the classroom for a period of time during the fourth year, to take one or more courses including a formal course in clinical pharmacology. Such an arrangement is already in place at several American medical schools (16,17).

There should be coordination between any required clinical pharmacology course and the basic pharmacology course at any medical school. Efforts should be made to make the second year course clinically relevant, without diluting the strength of the scientific approach to basic pharmacology. Also, it was recognized that some topics covered in the second year course in pharmacology (e.g. pharmacokinetics, drug metabolism, pharmacogenetics, drug abuse) formed the basis for subsequent lectures on the "same" topics in a clinical pharmacology course. Clearly a fourth-year lecture on pharmacogenetics would build upon, and be considerably more advanced than, a second year lecture on the "same" topic.

Required course format: There was agreement that no course format had been shown to be ideal, and that the actual format would have to be tailored to the circumstances at each medical school. Clearly, a lecture format would be most efficient, since most medical schools have very few faculty members in clinical pharmacology. However, active student participation should also be required to stimulate problem-solving skills,

and place proper emphasis on student-activated learning.

Such a course should be coordinated and primarily taught by a "general" clinical pharmacologist. Certain lectures could be taught by subspecialists, but the overall course thrust and coordination would require the expertise of a general clinical pharmacologist. It was recognized that such indivuduals are in short supply, that few new fellows are trained each year, and that the number of fellows may actually be dropping (18). In addition, some clinical pharmacologists might feel uncomfortable lecturing about some or all of these "core" subjects. However, clinical pharmacologists with adequate training in the field should be able to develop lectures on these topics and teach at a level conducive to learning by fourth year students. In fact, as standards for training programs for fellows and board certification appear more likely (19), clinical pharmacologists should feel more comfortable in their role as "generalists." The related issue of how to increase the number of medical residents interested in careers in general clinical pharmacology remains a chronic and difficult problem.

Other issues relevant to course format were discussed. At schools with few faculty members in clinical pharmacology, videotapes could be prepared to lessen faculty load, especially if a required course had to be repeated several times each year to include all students. The development of computer-assisted teaching devices would also serve a similar purpose. The month-long rotation on an active consultation service has been a valuable and popular way to teach fourth-year medical students, although its primary shortcoming is the ability to enroll only 1-3 students per month. In addition, such rotations are offered at a minority of medical schools.

The goals of teaching were also discussed. A required course in

clinical pharmacology should help the student master essential facts, skills, and attitudes in the area of general clinical pharmacology. As previously suggested (8,13), the skills (e.g. searching reference sources for information, analyzing papers and clinical studies, solving basic pharmacokinetic problems) and attitudes (e.g. personal plans for future drug education, desire to apply scientific principles to therapeutic decisions) may be as important as the current factual base of the discipline. Details of current therapeutics will certainly change, but an approach to life-long learning and rational therapeutics should be valid over time. The transmission of facts, and especially skills and attitudes, seems to require an interactive style of teaching with direct faculty-student contact. An over-reliance upon computer assisted teaching and videotapes might shortchange students in these areas. Active student participation (for example, presenting analyses of drug advertisements or of clinical cases) was felt to be a desired course characteristic, and would clearly require close faculty-student contact.

Future role of the ASCPT: The workshop participants felt that the ASCPT should consider taking a formal position to support the required teaching of general clinical pharmacology during the fourth year at all American medical schools. While such a position relates to other important issues (e.g. shortage of trained "general" clinical pharmacologists, accreditation of fellowship programs, board certification, etc.), the workshop participants felt that such a formal position should be seriously considered by the Society.

Other ways in which the Society could involve itself were also suggested. First, the Medical Education and Pharmacometrics Committees are now considering the establishment of procedures for evaluating software

programs useful in the teaching of clinical pharmacokinetics to medical students. At present, there are several programs in the public domain, and several others offered by private companies. Their evaluation in a systematic fashion would be of considerable benefit to faculty members seeking an appropriate program to supplement their courses.

Second, the Medical Education Committee has been very active in supporting CME programs for licensed physicians. The Committee may wish to pursue the issue of how best to involve the ASCPT in any future attempts to improve the quality of undergraduate medical training in clinical pharmacology.

Third, it was clear that the American Society for Pharmacology and Experimental Therapeutics (ASPET) has been interested in the education of medical students in pharmacology for quite some time. ASPET has a Committe on Educational Affairs, a Subcommittee on Teaching and Evaluation Materials, and an Executive Committee of the Clinical Pharmacology Division. The Medical Education Committee of the ASCPT is now considering ways of working with the relevant ASPET committees to coordinate plans to strengthen the teaching of clinical pharmacology within medical schools.

In summary, the workshop participants generally agreed that the discipline of clinical pharmacology has gained increasing visibility and respect from other medical disciplines. The student can practice rational therapeutics optimally only when he or she has mastered a "core" of material in general clinical pharmacology comprised of necessary facts, skills, and attitudes. Therefore, material which represents the "core essentials" of clinical pharmacology should be taught in required courses in all medical schools. The shortage of trained "generalist" clinical

pharmacocolgists, and the difficulty in changing medical school curricula, will make this an evolutionary process. Different solutions may be required at different medical schools. The relative merits of different formats and styles of teaching will have to be assessed, as well as the overall efficacy of our teaching endeavors upon medical student performance (1, 20). Nevertheless, as our Society moves forward with its efforts to define standards in training fellows and standards for board certification, it may also be time for the Society to consider taking a leadership role in bringing clinical pharmacology into the mainstream of medical school educational goals and required curricula.

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Table 1. Survey responses to topics in general clinical pharmacology. Each percentage represents positive responses from all those answering that question. Blank responses were not counted.

Topic	Should be required and taught	Present coverage adequate
Pharmacokinetics	98%	79%
Adverse drug reactions	95	73
Drug interactions	99	65
Therapeutic drug monitoring	91	45
Drug allergy	95	54
Pharmacogenetics	90	56
Prescription writing	84	74
Drug use in the elderly	97	50
Drug use in infants	97	38
Drug use in pregnant/lactating women	92	35
Drugs and the kidney	96	65
Drugs and the liver	96	59
Drug overdose/poisoning	95	71
Drug regulations	88	55
New drug development	72	45
Substance abuse	94	68
Learning about new drugs	90	44
Mean	92.3	57.4
SD	6.5	13.3

Table 2. Survey responses to topics in particular therapeutic areas. Tabulation of responses as in Table 1.

Topic	Should be required and taught	Present coverage adequate
Rx of obstetric conditions	88	28
Rx of pediatric conditions	91	39
Rx of surgical conditions	85	31
Rx of hematologic conditions	93	61
Rx of concologic diseases	94	70
Rx of cardiovascular diseases	97	77
Rx of pulmonary diseases	94	58
Rx of infectious diseases	97	69
Rx of rheumatologic diseases	96	67
Rx of renal conditions	94	58
Rx of neurologic diseases	96	61
Rx of gastroenterologic diseases	96	59
Rx of endocrine conditions	97	69
Rx of dermatologic diseases	90	41
Rx of allergic conditions	93	49
Rx of psychiatric diseases	97	59
Mean	93.6	56.0
SD	3.6	14.5

Survey of Public Affairs Activities of CAS Societies

This survey was undertaken in conjunction with COD and COTH surveys of the organizational structure with which individual institutions or societies within the AAMC governance handle public policy issues of interest. We wanted to improve our understanding of the full scope of public affairs contacts and activities within our constituency and to understand the mechanisms available to them to receive, disseminate and act upon AAMC memoranda or phone contacts concerning issues of importance to academic medicine.

Eighty-one of the 82 member societies responded. Almost all indicated that in their view one important way they participated in public affairs was through receiving information from AAMC, through discussions in CAS Administrative Board and Council and through the Association's response on their behalf on key legislative and regulatory issues.

In addition the survey revealed that some societies participated actively in public affairs through their own committees and staff, while many more were active in joint committees or less formal arrangements for information sharing and development of positions with other societies within their discipline. Table I shows that the chairmen's groups actively participate in public affairs most often through formal or informal information sharing and policy formulation within their discipline. Table II summarizes the intensity of public affairs activity by discipline. Many disciplines, through one or more of their societies, have ways of contacting all members and even activating a grassroots lobbying effort on key issues. Table III summarizes the responses to the survey questions.

Conclusion: This survey indicates that many societies participate in public policy activities in joint efforts within their discipline as well as on an interdisciplinary basis through the CAS/AAMC. The specific information obtained on the capabilities of individual societies should assist staff in their contacts with CAS members on key public policy issues.

Discussion: A number of societies expressed interest in how they might better organize and/or how other societies organized their public affairs activities. Should we present these survey results at the CAS Spring Business Meeting and provide an opportunity for active societies to describe and discuss the organization they have found effective in enhancing their participation in public affairs?

Table I. Public Affairs Activities of Chairmen's Group

I. Independently Active

1. Association of Professors of Dermatology
2. Association of Professors of Medicine

II. Jointly Active

A. Through Joint Committees

1. Association of Anatomy Chairmen
2. Society of Academic Anesthesia Chairmen
3. Society of Teachers of Emergency Medicine
4. Association of University Professors of Neurology
5. Association of Professors of Gynecology and Obstetrics
6. Association of Medical School Pediatric Department Chairmen

B. Informally through Academy, College or Research Organization

1. Association of Medical School Microbiology Chairmen
2. Association of Pathology Chairmen
3. Association for Medical School Pharmacology
4. Association of Chairmen of Departments of Physiology
5. Association of Teachers of Preventive Medicine
6. Association of Departments of Family Medicine
7. Society of Surgical Chairmen
8. Association of University Professors of Ophthalmology
9. Association of Orthopaedic Chairmen
10. Association of Academic Departments of Otolaryngology
11. American Association of Departments of Psychiatry
12. Thoracic Surgery Directors Association

III. Not Active

1. Society of University Urologists

IV. No Response

1. Association of Medical School Departments of Biochemistry

Table II. Public Affairs Activities of CAS Societies by Discipline

1. Grassroots Activity

   Anatomy
   Microbiology
   Anesthesia
   Dermatology
   Family Medicine
   Allergy and Immunology
   Obstetrics and Gynecology
   Ophthalmology
   Orthopaedics
   Otolaryngology
   Pediatrics
   Physical Medicine and Rehabilitation
   Radiology

2. Active Public Policy Committees

   Neuroscience
   Biochemistry
   Physiology
   Neurology

3. Legislative Tracking

   Pathology
   Pharmacology
   Preventive Medicine
   Plastic Surgery
   Thoracic Surgery

4. Emerging Interest

   Critical Care
   Emergency Medicine

5. No Interest

   Behavioral Sciences
   Urology

Internal Medicine, Surgery, and Psychiatry range from 1 to 5, based on the individual societies' responses.

Table III CAS Public Affairs Survey Responses:
81 of 82 Societies responding

1. Does your society have a public or legislative affairs committee?

	YES	NO
Basic	15 (88.2%)	2 (11.8%)
Clinical	30 (46.9%)	34 (53.1%)
TOTAL	45 (55.6%)	36 (44.4%)

2. Does your society participate with other societies in the areas of public or legislative affairs?

	YES	NO
Basic	15 (88.2%)	2 (11.8%)
Clinical	30 (46.9%)	34 (53.1%)
TOTAL	45 (55.6%)	36 (44.4%)

3. What types of mechanisms do you use for these joint efforts? (Note: Some respondents selected more than one mechanism.)

	Basic	Clinical	TOTAL
Ad Hoc Coalitions	10	28	38
Standing Committees	7	22	29
Individual Contacts	5	3	8
Staff Contacts	1	2	3
Others	1	7	8

4. Does your society have a mechanism for rapid communication with the membership for urgent lobbying of legislative issues?

	YES	NO
Basic	10 (58.9%)	7 (41.1%)
Clinical	36 (56.2%)	28 (43.8%)
TOTAL	46 (56.8%)	35 (43.2%)

If so, what type of mechanism is used?
(Note: Some respondents selected more than one mechanism.)

	Basic	Clinical	TOTAL
Telephone Cascade	8	19	27
Mailgrams	2	18	20
Express Mail	3	10	13
Mail	0	4	4
Newsletter	0	3	3
Electronic Mail	0	2	2

Who is contacted?
(Note: Some respondents selected more than one choice.)

	Basic	Clinical	TOTAL
Officers	5	20	25
Public Policy Committee	7	14	21
Full Membership	3	17	20
Board of Directors	2	12	14
Grass Roots	1	4	5
Select Members	1	4	5
Program Directors	1	1	2

A number of societies indicated that the subset of members contacted is dependent upon the nature and urgency of the issue.

5. Does your society have a mechanism for grass roots lobbying?

	YES	NO
Basic	4 (23.5%)	13 (76.5%)
Clinical	24 (37.5%)	40 (62.5%)
TOTAL	28 (34.6%)	53 (65.4%)

If so, is it organized by:
(Note: Some respondents selected more than one choice.)

	Basic	Clinical	TOTAL
Congressional District	1	6	7
Medical School	2	5	7
State	0	6	6
Academic Medical Center	1	3	4
State, Local or Regional Societies	0	4	4
Others	1	12	13

6. Does your society have a newsletter?

	YES	NO
Basic	13 (76.5%)	4 (23.5%)
Clinical	46 (71.9%)	18 (28.1%)
TOTAL	59 (72.8%)	22 (27.2%)

If so, how often is it sent?

Twice monthly	2
Monthly	7
6 times/year	11
4 times/year	17
2-4 times/year	9
2 times year	10
"Occasionally"	2

To whom is it sent?

Full Membership	50
Board	4
Officers	2
Public Affairs Cmte	1
Grass Roots	1
Others	1

7. Does your society have any other means of regular written communication with the membership?

	YES	NO
Basic	10 (58.8%)	7 (41.2%)
Clinical	51 (79.7%)	13 (20.3%)
TOTAL	61 (75.3%)	20 (24.7%)

If so, is it:
(Note: Some respondents selected more than one choice.)

Society Journal	34
President's Letters	24
Memoranda	11
Meeting Notices and Minutes	5
Legislative Info to Chapters	1

8. Does your society have a professional staff for public and legislative affairs?

	YES	NO
Basic	7 (41.2%)	10 (58.8%)
Clinical	25 (39.1%)	39 (60.9%)
TOTAL	32 (39.5%)	49 (60.5%)

Council of Academic Societies
1987 Spring Meeting

"SIZING UP THE FUTURE OF MEDICAL EDUCATION"

March 18-20, 1987
The Woodlands Inn
The Woodlands, Texas

Wednesday, March 18 — Registration 4:00 - 6:00 p.m.

KEYNOTE ADDRESS

Edward N. Brandt, Jr., M.D. Ph.D.
Chancellor, University of Maryland
Member, AMA Task Force on Physician Manpower

Reception and Dinner to follow

Thursday, March 19 — Council Forum 8:30 - 1:00 p.m.

"SIZING UP THE FUTURE OF MEDICAL EDUCATION"

Modulating physician supply: critical issues

Frank G. Moody, M.D.
CAS Chairman

Reducing the supply of physicians: what impact for our academic missions?

	MISSION	DISCUSSION LEADER
9:00 - 10:15	Education	Jack M. Colwill, M.D. Chairman, Family & Community Medicine University of Missouri - Columbia
10:30 - 11:45	Research	David H. Cohen, Ph.D. Vice President for Research/ Dean, Graduate School Northwestern University
11:45 - 1:00	Patient Care	Gerald S. Levey, M.D. Chairman, Task Force on Internal Medicine Manpower, APM Chairman, Dept. of Medicine University of Pittsburgh

KEYNOTE ADDRESS 6:00 p.m.

Robert G. Petersdorf, M.D.
President, AAMC

Reception and Dinner to follow

Friday, March 20

CAS Business Meeting 8:30 a.m. - 12:00 noon