



**association of american
medical colleges**

AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES

WEDNESDAY, SEPTEMBER 7, 1988

**CAS BOARD MEETING
4:45 - 6:00 P.M.
GRANT ROOM**

**JOINT BOARDS SESSION
6:00 - 7:00 P.M.
CONSERVATORY**

**CAS ADMINISTRATIVE BOARD RECEPTION AND DINNER
7:00 - 9:00 P.M.
STATE ROOM**

THURSDAY, SEPTEMBER 8, 1988

**CAS BOARD MEETING
8:00 AM - 12:30 P.M.
JACKSON ROOM**

**JOINT BOARDS LUNCH
12:30 - 1:30 P.M.
CONSERVATORY**

**EXECUTIVE COUNCIL BUSINESS MEETING
1:30 - 4:00 P.M.
JEFFERSON ROOM WEST**

**WASHINGTON HILTON HOTEL
WASHINGTON, D.C.**

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

SCHEDULE
September 7-8, 1988

Wednesday, September 7, 1988

4:45 - 6:00 p.m.	CAS Administrative Board Meeting	Grant Room
6:00 - 7:00 p.m.	Joint Boards Session with Guest Speaker Donald Ian MacDonald, M.D.	Conservatory
7:00 - 9:00 p.m.	CAS Administrative Board Reception and Dinner	State Room

Thursday, September 8, 1988

8:00 a.m. - 12:30 p.m.	CAS Administrative Board Meeting	Jackson Room
12:30 - 1:30 p.m.	Joint Boards Luncheon	Conservatory
1:30 - 4:00 p.m.	Executive Council Business Meeting	Jefferson Room West

DATES TO REMEMBER

AAMC Annual Meeting Chicago, Illinois	November 12-17, 1988
Administrative Board/Executive Council Washington, D. C.	February 22-23, 1989
CAS Spring Meeting Orlando, Florida	March 15-17, 1989
Administrative Board/Executive Council Washington, D. C.	June 14-15, 1989 September 27-28, 1989
AAMC Annual Meeting Washington, D. C.	October 28-November 2, 1989

CORRECTION

Please note the following correction to the CAS Administrative Board minutes on page 18.

The line now reading "...develop a proposal for teaching awards for biomedical research...." should be changed to read "...develop a proposal for grants for excellent teachers/researchers...."

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Wednesday, September 7, 1988
4:45 - 6:00 p.m.
Grant Room
Washington Hilton Hotel
Washington, D. C.

I. Action Item

A. Liaison Project Reports

1. Issues constituent societies would like addressed by
AAMC/CAS in 1989.....Y1
2. AAMC Dues Increase.....Y3
3. Other results of the Liaison Project

II. Discussion Item

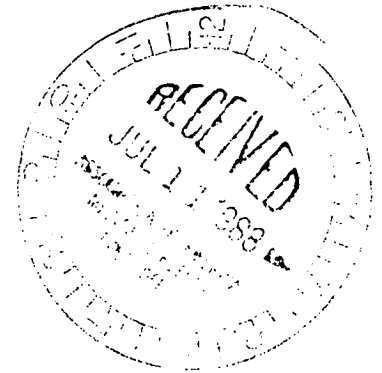
A. Reports from the Working Groups

1. Innovative Educator Grant Program
Douglas E. Kelly, Ph.D., Chairman
2. Faculty Development/Evaluation
Joe Dan Coulter, Ph.D., Chairman
3. Initiatives to Address Discontinuities in Medical Education
Frank G. Moody, Chairman

Association of Pathology Chairmen, Inc.

University of Cincinnati Medical Center
College of Medicine
Department of Pathology
and Laboratory Medicine
231 Bethesda Avenue
Cincinnati, OH 45267-0529

July 5, 1988



Robert G. Petersdorf, M.D.
President, Association of American Medical Colleges
1 Dupont Circle, NW
Washington, DC 20036

Dear Dr. Petersdorf:

As you know, the Association of Pathology Chairmen has, for some time, been concerned about the uneven utilization of the autopsy in the United States. The current low rate, near 12% overall and 31% in academic medical centers, and the poor utilization of autopsy findings interferes seriously with the education of medical students, quality control of hospital practice, continuing education of practicing physicians, provision of reliable health statistics, advance of medical science and a host of other crucial activities.

Among the autopsy-related initiatives that the APC is currently spearheading or strongly involved in are: A) the generation of the funds required for an IOM study on the desirability of a national autopsy policy; B) improvement in the quality of autopsy performance; C) re-prioritization of the uses of the autopsy in academic medical centers.

In addition to the above, we would like to catch the attention of the ACGME and the LCME. We have made a presentation to the ACGME which was enthusiastically received, concerning the importance of the autopsy in all training programs in academic institutions. Reaching the LCME is more difficult, and we would hope that the AAMC might take the initiative in this arena.

Less than half of the medical schools of this country currently require their students to attend even one autopsy; in the other schools, the requirement is usually a single case. It is difficult for physicians of our generation to visualize learning about the nature of disease without the opportunity to observe autopsies. Those of us on the firing line can attest that today's house officers are painfully, perhaps dangerously, unaware of the nature of tissue abnormalities that seem to characterize specific diseases and the spectrum of iatrogenic complications that are frequently significant and usually unexpected.

We recognize only two major objections to increasing autopsy rates from the point of view of regulatory bodies. The first has to do with the fear that finding a mistake at autopsy will inevitably escalate to litigation. We are

Robert G. Petersdorf, M.D.

July 5, 1988

Page Two

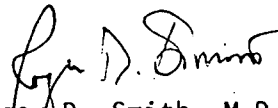
mounting a study that will answer whether autopsies help or hinder in this regard, but, meanwhile, the opinion of attorneys who defend physicians in malpractice actions seem to be that they wish autopsies were universal--facts are better than inuendos. The second is the incremental cost. Again, we are collecting national data related to the cost of the autopsy in various environments. However, we do know that the major cost of an autopsy particularly in a large medical center has to do with the high fixed cost of maintaining an autopsy service, not with the number of cases. An autopsy room with a capacity of conducting 500 or more cases is obviously sitting idle most of the time if only 150 cases are referred.

We have unequivocal data that chairmen of departments of medicine and surgery in U.S. medical schools deplore the current low rate. It is quite compelling to note that questionnaires and survey forms to all medicine, surgery and pathology departments returned almost the exact same desirable autopsy rate for an academic institution: 62%, which is just double the present average rate.

We do not presume at this time to suggest a course of action for the AAMC. We would, however, be more than pleased to meet with you to discuss alternative proposals, such as a certain number of autopsies available per student for LCME accreditation of a residency or a hospital percentage required for membership in COTH. We also have some more imaginative schemes related to utilization rather than numbers.

Thank you for your attention to the above. Best personal regards.

Sincerely yours,



Roger D. Smith, M.D.
President

RDS/jt



association of american medical colleges

August 4, 1988

Dear Colleague:

As the principal officers of the Association of American Medical Colleges, we are writing to all of the Association's members about the proposed dues increase that will be brought before the membership at the annual Assembly meeting in Chicago on November 14. This marks the first time since 1978 that members have been asked to revise the Association's basic dues structure. For the past year the Executive Committee of the Association has been engaged in developing a financial plan for the AAMC that will meet its immediate needs and provide for strengthening its programs so that the Association can continue its vital leadership as an advocate for the welfare of academic medicine. We believe that the proposal for modified dues, as described in the enclosed memorandum from AAMC President Robert G. Petersdorf, will meet these objectives. We urge your careful perusal of this document, which parallels his reports to the spring meetings of the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals. We call your particular attention to the section on member services, which describes the benefits of AAMC membership.

We believe that the Association and its staff have been exemplary advocates for academic medicine and that their record of accomplishment should speak for itself as you consider what the AAMC provides for its members. We also believe it is appropriate to be aware that membership in the Association brings benefits beyond the services and programs described in the memorandum. The advocacy activities of the Association have been instrumental in financial and substantive gains for academic medicine as well, as is demonstrated by two recent examples:

--The level of the indirect medical education adjustment under Medicare is in constant jeopardy as efforts are made to bring the federal deficit under control. In FY 88 the President's budget proposal called for reducing the adjustment from 8.1 percent to 4.05 percent. (If adopted, this would have reduced indirect medical education allowances by \$870 million.) The AAMC was the most vigorous opponent of the President's proposal, and Congress was persuaded to retain the adjustment at 8.1 percent for FY 88 and 7.7 percent for FY 89.

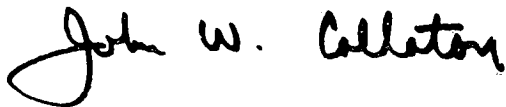
--In its FY 88 budget the Reagan Administration also proposed delaying the expenditure of \$334 million of NIH funds and \$5 million of ADAMHA funds into the next fiscal year, reducing the number of competing research grants by more than 700 and cutting research project grants by at least 10 percent. The AAMC believed that implementation of this proposal without congressional approval was illegal and retained counsel for legal action. Other co-plaintiffs were invited to join the suit, and congressional attention to this proposal

was solicited. Shortly thereafter grants were funded according to normal procedures and funds were restored to grants that had been reduced. Eventually Congress formally rejected the proposed reappropriation.

It is our belief that membership in the AAMC is an investment that helps protect the strength and vitality of its members. Improved financial strength will allow the Association to pursue its effective advocacy for academic medicine, while maintaining vital programs and services on which our members have come to rely. We hope we can count on your support for this proposal in November.

In accord with AAMC President Petersdorf's invitation in his memorandum, please feel free to call any of your elected representatives or the Association staff if you have any questions about the proposal.

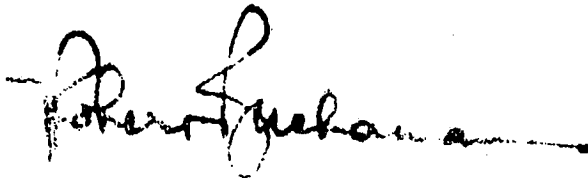
Sincerely,



John W. Colloton
AAMC Chairman



William T. Butler, M.D.
Chairman, Council of Deans



J. Robert Buchanan, M.D.
Chairman, Council of Teaching
Hospitals



Douglas E. Kelly, Ph.D.
Chairman, Council of Academic
Societies



association of american medical colleges

August 4, 1988

MEMORANDUM

TO: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Financial Plan for the Association of American Medical Colleges

At its last meeting the Association's Executive Council voted to recommend to the Assembly the adoption of a new dues structure for the principal categories of Association membership. Final action on the proposal will be taken at the November 14 meeting of the Assembly in Chicago.

This memorandum provides background information on the development of a dues proposal that allows the Association to meet its financial objectives. It should answer questions about why the dues increase is necessary and the benefits members receive for their dues. After reviewing the material you are invited to discuss any questions you might have with a member of your Administrative Board (lists attached) or with the appropriate AAMC staff:

COD: Gus Swanson (202) 828-0475
Lou Kettel (202) 828-0580

CAS: John Sherman (202) 828-0470

COTH: Jim Bentley (202) 828-0490

The Association's officers and staff are aware of the fiscal constraints that face our members, and the dues proposal has been carefully crafted with this in mind. We believe the range of programs offered by the Association to serve your needs and to represent your views to policy-makers is exceptional. Nevertheless, the need for innovative approaches to education, research, and service issues and aggressive representation of academic medical centers has not diminished. The new dues structure will provide the financial resources necessary to continue the Association's strong record of leadership for academic medicine.

HISTORY AND CURRENT DUES STRUCTURE

The Association's last two increases in the base calculations for medical school dues occurred in 1968 and again in 1978. For teaching hospitals and academic societies the last dues modifications were in 1973 and 1978. At the time the transition of Association leadership was announced in the spring of 1986 it was evident that a dues increase would be necessary to prevent a deficit between revenues and expenditures, but it was decided to delay enactment of a new dues structure until there had been an opportunity to review the programs and priorities of the Association in conjunction with the change in leadership.

The dues structure that was adopted at the 1978 annual meeting was meant to keep the Association's revenues in step with inflation without the continual need for a reauthorization of increased dues by the constituency. To this end, the formula that was developed provided for an annual adjustment of the dues based on inflation. While it was originally believed that this policy would meet the Association's needs for an indefinite period, 10 years was too long to pass without revising the basic dues structure.

There are several reasons why the 1978 formula no longer meets the Association's needs:

Dues inflator insufficient for growth of total revenues: dues are not the only source of income, and have traditionally been less than one-third of the Association's revenue. An annual inflationary adjustment based only on the dues segment of income was not able to provide growth in total revenues sufficient to keep pace with inflation.

Declining revenues: Changes are occurring in other sources of Association revenue, and the current dues structure does not provide an opportunity to compensate for those changes.

No program growth: A dues structure with only inflationary increases, in effect, locks in present programs and provides no margin for the initiation of new programmatic activities.

CURRENT FINANCIAL STATUS

Three aspects of the Association's current financial status are important in considering the dues increase.

Revenue curve has flattened: The Association's revenue curve has been relatively flat since 1982. In FY 1987 there were five general categories that produced more than 4% of the Association's general funds income:

- 30% from member dues and service fees
- 45% from special services
- 4% from publications
- 4% from sundry sources, primarily the annual meeting
- 16% from investment income

Special services revenue is generated primarily from the Medical College Admission Test (MCAT), the American Medical College Application Service (AMCAS), and the MEDLOANS program. For many years the large number of applicants resulted in service fees which allowed the Association to keep dues artificially low in comparison to services rendered. With the decrease in the number of MCAT test takers and medical school applicants, the Association's reliance on this income stream is necessarily reduced. While the Association will continue to raise the price of these services so that costs are covered, this source of income can no longer underwrite general Association activities.

Operational deficit: The decision to postpone a dues increase in 1986 meant that the Association would probably incur deficit budgets until such time as a dues increase was enacted. A balanced budget was achieved in FY87

because the governance authorized the use of realized gains from the equity portfolio (reserves) to finance expenses related to the transition of leadership at the Association. In fiscal year 1988 the Association's budget was close to equilibrium. However, this equilibrium was achieved by using funds from special designated reserves and investment income of more than \$1,000,000. For FY89 the Executive Council has approved a general funds budget with a deficit of \$1.281 million.

Reserves supporting general operations: Currently the Association's operational deficit is being met by its reserve capital. It should also be understood that the Association's investment income has for several years been a budgeted source of general operating income. This means that the reserve principal cannot be used for special purposes because of the need for the investment income, and it also means that the value of the reserves is not being maintained since the interest does not accrue to the corpus.

REASONS FOR A DUES INCREASE

In reviewing the Association's current financial status, the Executive Council supported a dues increase for the Association for the following reasons:

Program improvements: Program improvements made at the Association have increased operating expenses. For example, the Association has added additional senior staff to increase its analytical and programmatic capabilities. Government relations, faculty practice, biomedical research, minority affairs, and communications and media relations have been upgraded in the AAMC organizational structure to provide the resources necessary to improve AAMC programs.

New programs: The Association should not be a static organization. It must be equipped to provide leadership for academic medicine. Although the range of current AAMC programmatic activities is broad, there are now new arenas in which the Association must become active. These include:

- expected changes in physician reimbursement and other faculty practice issues

- follow-up to the GPEP study on medical school curriculum

- significant expansion in minority affairs activities to reflect the reality of our nation's changing demographics

- expanded database and research on teaching hospital operations and financing

- response to increasing public concerns about fraud and misconduct in scientific investigation

- improved image for the profession to increase the attractiveness of medicine as a career

- expanded analysis of physician supply and demand issues

--targeted response to specific health care issues such as AIDS

--new emphases on teaching and evaluation methodologies, particularly in the clinical arena and with specific reference to increased educational activities in ambulatory settings

--response to new proposals impacting on the research enterprise including privatization of the National Institutes of Health and new animal rights proposals

--programs to enhance the leadership potential of women in academic careers

--Academic Medicine, a revised and improved successor to the Journal of Medical Education

--participation in the new International Medical Scholars Program

--analyses of evolving industry-academe-government relationships in biomedical research

--development of a strategy to update research facilities

Databases: The Association has a commitment to enhance its leadership capabilities by maintaining sophisticated and growing databases. Several databases have been instituted since the last dues increase, including the hospital operations database and the massive Student and Applicant Information Management System (SAIMS), which is so important in this time of declining medical school applications.

Decline in other sources of support and appropriateness of dues as additional source of revenue: The Association's current dues structure provides approximately 30% of the Association's revenues, and is one of the few sources of income over which the Association exercises a measure of control. It also provides the most flexibility in terms of new program initiatives. It is no longer realistic to expect the Association's special services program to generate sufficient funds to underwrite general Association membership services, and it is appropriate that increased dues income be used for this purpose.

Salary adjustments: Resources are required to retain and attract a qualified staff. Adjustments have been made in the salaries of the executive staff, whose compensation had been low in relation to their abilities and seniority as well as in comparison with similar positions at AAMC member institutions. Adjustments were also made for FY89 in administrative assistant salaries, which had fallen well below local market levels. The Association remains behind the local labor market in several categories, and expects the period of salary adjustment to continue for 2 or 3 more years.

Space requirements: The Association needs both additional and more functional space than it currently has. The Association is currently split between two locations which increases communication costs and makes coordination of activities more difficult. Since the Association pays more than

\$1,000,000 annually in rent, the Finance Committee has recommended that the Association look for a building in which it can have an equity position and some control over future occupancy costs.

Protection of reserves: The Association is fortunate to enjoy a strong financial reserve position, which provides both flexibility and stability to the Association's operations. Currently, the use of these reserves to support ongoing operations through the use of investment income for general operating expenses, for Council-designated special projects, and to underwrite the operating deficit precludes real growth in the Association's reserves.

FINANCIAL PLAN

The Executive Council has developed a financial plan that will increase dues income to provide financial stability for the Association. It has four major objectives:

1. **Replace declining services income:** It is appropriate that dues be used to compensate for falling MCAT and AMCAS revenues since the Association's general programs benefit its dues-paying members.
2. **Discontinue use of reserves for operations:** The new financial plan will allow the Association to discontinue funding of some ongoing programs from special reserves and to move these expenditures into the general operating budget. The Association has held funds in Council-designated reserves for specific program activities. Since some of these activities are now ongoing operational expenses, moving these expenditures from reserves to the general funds budget provides a clearer picture of the Association's activities and their financial characteristics.
3. **Cover projected program growth:** The Executive Council strongly believes that the Association must be prepared to undertake new programmatic initiatives previously discussed in this memorandum.
4. **Discontinue use of investment income for operations:** The Association should discontinue its reliance on investment income to support program operations. During the 1970s when interest rates were very high, the Association achieved significant growth in reserves by adding investment income to investment corpus. In the past few years, when the Association has been overdue for a dues increase, this investment income has served as a source of operating funds. It is to the long-term benefit of the Association to develop a financial plan that does not use investment income for operations.

The Association's Executive Committee has proposed designating future investment income for a capital fund that will allow a long-term solution to the Association's space requirements. The use of these funds for investment in a building that the Association would occupy has several benefits: 1) solve immediate space problems; 2) control future occupancy costs; 3) provide diversification of the Association's investment portfolio; and 4) allow investment income to contribute to the growth of the Association's assets rather than to support current operating expenses.

The cost of implementing the financial plan is \$4,600,000:

To meet current deficit	\$1,300,000
To move ongoing expenditures reserves to operating budget	700,000
To replace investment income as a source of operating funds	1,200,000
For inflation and new programs	1,400,000

DUES PROPOSAL

The table below presents the proposed dues structure that will meet the Association's financial plan. Under the proposal, dues will provide about 50% of the Association's income, compared to 30% at present. While the dues proposal is substantial, it is not an unreasonable amount to support the services the Association provides to its members.

	<u>FY89</u>	<u>FY90</u>
Medical Schools	18,900	32,500
Teaching Hospitals		
General	2,745	10,000
Federal	2,745	4,800
Corresponding	930	2,400
Academic Societies		
LT 300 members	930	1,300
300-999 members	1,890	2,600
1,000 - 4,999 members	3,735	5,200
5,000 and over	5,600	6,300

Medical school dues currently have two components: a base dues of \$3,000 plus a service fee calculated on the school's budget, with an FY89 cap on dues of \$18,900. Under this proposal, medical school dues will be set at \$32,500 for FY90. Since all medical schools receive essentially the same services from the Association and since all but one medical school currently pays the maximum dues amount, a flat fee dues structure is deemed appropriate.

All members of the Council of Teaching Hospitals will pay dues of \$2745 in FY89. For FY90 the proposal includes a differentiated dues structure for teaching hospitals, with full non-federal members paying \$10,000 and federal members paying \$4,800. This is proposed in recognition that much of the Association's work in support of reimbursement issues is not relevant to the operations of federal hospitals. Corresponding members will continue to have a lower dues rate, set in the future at \$2,400 compared to the current \$930.

The Council of Academic Societies has traditionally had a sliding fee schedule for dues recognizing differences in the size of the constituent societies; this practice is continued under the new proposal.

In future years the dues will be adjusted by the Higher Education Price Index, and the level of dues will be reviewed by the Finance Committee every three years.

SERVICES TO MEMBERS

As you consider the dues proposal on which the Assembly will vote in November, it is useful to review the member services provided by the Association. A complete description of the Association and its programs can be found in the AAMC annual report, but the following should be a sufficient reminder of the specific activities undertaken by the AAMC on behalf of its members.

The Association maintains an active liaison with the Congress and the executive branch on issues of concern to medical schools, teaching hospitals, and faculties. These issues include student financial assistance, support for biomedical and behavioral research and research training, reimbursement for medical services under Medicare and Medicaid, education, research and patient care programs of the Veterans Administration, and other more specialized issues. So far during the 100th Congress, the Association has testified on 17 occasions and commented many times on regulations from the executive branch. These issues are brought to the attention of the Association's constituents at crucial points in the legislative and regulatory processes so that AAMC members can make their views known directly to their congressional delegation and executive branch officials. Additionally, the Association provides technical assistance to state legislatures considering special legislation impacting on medical education.

On occasion the Association engages in litigation to protect some essential aspect of academic medical centers.

Through its medical school, teaching hospital, and academic society members, the Association provides a unique forum for communication among leaders of these important participants in medical education.

Accreditation activities of the Liaison Committee on Medical Education assure the continued high quality of U.S. medical schools. The LCME makes regular accreditation surveys and special consultation visits during critical periods of an institution's development.

Through AAMC membership on the Accreditation Council for Graduate Medical Education, and the Accreditation Council on Continuing Medical Education, the views of academic medicine are incorporated in the formulation of policies for the accreditation of graduate and continuing medical education programs.

The AAMC sponsors the Medical College Admission Test which serves as a national norm by which medical schools can evaluate and assess applicants' cognitive skills. The MCAT is not a static instrument; the Association is continually concerned about its updating and improvement. The test was last revised in 1977 and is currently undergoing further revision.

The American Medical College Application Service is available to all AAMC members. Participants receive complete application packets for students. This service enables the applicant to file a single application to multiple

schools, saving the student much time and money. AMCAS reports include joint acceptance reports and statistical information on the average MCAT scores for national and regional applicant pools. The AMCAS system also keeps data and reports on matriculants, enrollees, and graduates of all U.S. medical schools.

The Association offers MEDLOANS, a comprehensive loan program in which medical students can apply for three federal loan programs and a new Alternative Loan Program through a consolidated application procedure.

Each year the Association surveys graduating senior medical students on a variety of factors including their background, medical school experiences, and their future plans for residency, type of practice, specialty choice, and expected practice location. Each school is provided with a detailed description of its graduates compared to the national pool. Additionally, graduates are asked to provide comments on the strengths and weaknesses of their schools, and these essays are returned to the school for review. Last year the AAMC initiated the Matriculating Student Questionnaire to provide data on entering students.

The Association's routine publications include the monthly refereed Journal of Medical Education, the President's Weekly Report, the Council of Teaching Hospitals (COTH) Report, and the annual Directory of American Medical Education, Curriculum Directory, and an annual listing of Medical School Admission Requirements. Eight other periodical publications are distributed to selected subgroups of the Association's constituency.

The Association's annual meeting is the most important gathering of medical educators in this country. The Association also conducts special topic seminars such as the recent national conference on applicants and admissions.

The Association conducts management education programs to improve the administrative capabilities of medical center executives. In addition to the basic executive development course, special seminars are offered on managing information technology, clinical evaluation, and problem-based learning.

The Association has six affinity groups devoted to strengthening the professional skills of individuals within the academic medical center community: business officers, institutional planners, student affairs officers, faculty practice managers, medical education researchers, and public affairs personnel, including alumni and development officers.

The Association maintains an extensive database on medical schools, including information on financial support, students, and faculty. There are more than 20,000 items in the Institutional Profile System for each school with records spanning two decades. The comprehensiveness of this system means that individual schools do not have to duplicate this extensive data collection and storage effort. A report comparing each school to all other schools is distributed annually.

The Association has established a coordinated database on teaching hospital costs and operating characteristics so that the impact of policy proposals can be assessed on different types of teaching hospitals.

The Association's Faculty Roster maintains information on all U.S. medical school faculty. Many studies about characteristics of the faculty emanate from this database. The Faculty Roster can also be used as a tool for recruiting minorities and women and to fill faculty vacancies. One of the Association's most important publications is an annual faculty salary survey with information on compensation of full-time faculty presented by discipline, degree, faculty rank, and region. Compensation surveys are also distributed on deans and teaching hospital executives.

The Association conducts special studies on issues of particular importance to academic medical centers. Although outside support for these projects is sometimes obtained, some are supported entirely by Association funds and, in all cases, the Association cost shares in the venture. Among the special projects now underway are a major review of physician supply and its relationship to medical education, a pilot program to use an essay question as part of the MCAT exam, and an examination of issues related to Acquired Immune Deficiency Syndrome and the Academic Medical Center.

The Association has been actively engaged in effecting changes in the transition from medical school to residency. It has taken the responsibility for deriving a community consensus on such matters as timing of deans' letters, the advisability of "audition" electives, and changes in the timetable for the National Resident Matching Program.

The Association has acted as a catalyst in the formation of a number of coalitions designed to advance the needs of academic medicine and provide staff support for their efforts. These include the ad hoc Group on Medical Research Funding and the Friends of the Veterans Administration. The Association and its staff have also taken leadership roles in the activities of other organizations, again to represent the views of its members. These include service on the steering or working committees and boards of organizations such as the National Association for Biomedical Research, the Institute of Medicine Committee on NIH Intramural Research Programs, the Affiliations Subcommittee of the IOM Committee to Study VA Physician Manpower Requirements, and the Association for Health Services Research.

The Association acts as a clearinghouse on all aspects of medical education and academic medical center activities, either providing assistance directly through contact with AAMC staff or by putting members in touch with colleagues at other institutions.

CONCLUSION

The dues proposal will be presented for final action at the Assembly meeting in Chicago on Monday, November 14. Your vote in support of the proposal will assure the Association's continuing ability to serve the needs of academic medicine. Please give this matter your careful consideration and discuss any questions with your Administrative Board or with Association staff. The Association's strong advocacy for academic medicine is possible only with the support and backing of its members.

COUNCIL OF DEANS

1987-88 ADMINISTRATIVE BOARD

WILLIAM T. BUTLER, M.D.
Chairman
President
Baylor College of Medicine
1200 Moursund
Houston, TX 77030
(713) 799-4846

WILLIAM B. DEAL, M.D.
Chairman-elect
Associate Vice President
for Clinical Affairs and Dean
University of Florida
College of Medicine
Box J-215, J. Hillis Miller
Health Center
Gainesville, FL 32610
(904) 392-3701

Executive Council Representatives:

L. THOMPSON BOWLES, M.D., Ph.D.
Vice President for Medical
Affairs
Dean for Academic Affairs
George Washington University
Medical Center
2300 Eye Street, NW
Washington, D.C. 20036
(202) 994-3727

JOHN NAUGHTON, M.D.
Vice President for Clinical
Affairs and Dean
SUNY - Buffalo
School of Medicine and
Biomedical Sciences
3435 Main Street
Buffalo, NY 14214
(716) 831-2775

RICHARD S. ROSS, M.D.
Vice President for Medicine and
Dean of the Medical Faculty
Johns Hopkins University
School of Medicine
720 Rutland Avenue
Baltimore, MD. 21205
(301) 955-3180

ROBERT E. TRANQUADA, M.D.
Dean
University, Southern Calif.
School of Medicine
2025 Zonal Avenue
Los Angeles, CA 90033
(213) 224-7001

W. DONALD WESTON, M.D.
Dean
Michigan State University
College of Human Medicine
East Lansing, MI 48824
(517) 353-1730

Members-at-Large:

GEORGE T. BRYAN, M.D.
Vice President for Academic
Affairs and Dean
University of Texas
Medical School at Galveston
301 University Blvd.
Galveston, TX 77550
(409) 761-2671

PHILLIP M. FORMAN, M.D.
Dean and Professor, Clinical
Pediatrics & Neurology
University of Illinois
College of Medicine
1853 West Polk Street
Chicago, IL 60612
(312) 996-3500

ROBERT L. FRIEDLANDER., M.D.
Executive Vice President for
Academic Health Sciences and
Dean
Albany Medical College
47 New Scotland Avenue
Albany, NY 12208
(518) 445-5544

HENRY P. RUSSE, M.D.
Vice Pres., Medical Affairs
and Dean
Rush Medical College
of Rush University
600 South Paulina Street
Chicago, IL 60612
(312) 942-8389

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(212) 430-2801

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(713) 792-5400

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(608) 263-8100

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*American Society for Pharmacology and
Experimental Therapeutics*
Department of Pharmacology
USUHS School of Medicine
4301 Jones Bridge Road
Bethesda, Maryland 20814
(301) 295-3223

Joe Dan Coulter, Ph.D. (88)
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University of Iowa College of Medicine
Iowa City, Iowa 52242
(319) 335-7766

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University of California Medical Center
San Francisco, California 94143
(415) 476-1869

Myron Genel, M.D. (90)
American Pediatric Society
Associate Dean for Government/Community Affairs
Yale University School of Medicine
P. O. Box 3333
New Haven, Connecticut 06510
(203) 785-6019

Glenn C. Hamilton, M.D. (88)
Society of Teachers of Emergency Medicine
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Wright State University School of Medicine
P. O. Box 927
Dayton, Ohio 45401
(513) 276-8331

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Columbia University College of Physicians
and Surgeons
622 West 168th Street
New York, New York 10032
(212) 960-2500

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Association of Pathology Chairmen
Chair, Department of Pathology
Howard University College of Medicine
520 W Street, N. W.
Washington, D. C. 20059
(202) 636-6306

Joel Sacks, M.D. (90)
American Academy of Ophthalmology
Department of Ophthalmology
University of Cincinnati School of Medicine
231 Bethesda Avenue, ML 527
Cincinnati, Ohio 45267
(513) 872-5151

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713/791-2011

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6565 Fannin
Houston, TX 77030
713/790-3366

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Georgetown University Hospital
3800 Reservoir Road NW
Washington, DC 20007
202/625-7001

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University of California, LA
10833 Le Conte Avenue
Los Angeles, CA 90024
213/825-5041

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Executive Council

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Chairman/CEO
New England Medical Center, Inc.
750 Washington Street
Boston, MA 02111
617/956-7655

WILLIAM H. JOHNSON JR
Administrator
University of New Mexico Hospital
2211 Lomas Boulevard NE
Albuquerque, NM 87106
505/843-2121

BARBARA A. SMALL
Medical Center Director
Veterans Administration
Medical Center
508 Fulton Street
Durham, NC 27705
919/286-0411, X-6219

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President
Rush-Presbyterian-St. Luke's
Medical Center
1753 W. Congress Parkway
Chicago, IL 60612
312/942-5000

MAX POLL
President
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Barnes Hospital Plaza
St. Louis, MO 63110
314/362-5000

C. EDWARD SCHWARTZ
Executive Director
Hospital of the University
of Pennsylvania
3400 Spruce Street
Philadelphia, PA 19104
215/662-2992

JAMES J. MONGAN, MD, Ex-Officio Member*
Executive Director
Truman Medical Center
2301 Holmes Street
Kansas City, MO 64108
816/556-3149

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Thursday, September 8, 1988
8:00 a.m. - 12:30 p.m.
Jackson Room
Washington Hilton Hotel
Washington, D. C.

AGENDA

- I. Chairman's Report -- *Douglas E. Kelly, Ph.D.*
- II. President's Report -- *Robert G. Petersdorf, M.D.*
- III. Action and Discussion Items
- A. Approval of Minutes.....Y17
 - B. Nominating Committee Report.....Y23
 - C. Distinguished Service Member Nominations.....Y24
 - D. Council of Academic Societies Membership Criteria.....Y25
 - E. Committee on AIDS: Report on Institutional Policies.....B19
 - F. Medicare Policy Issues for 1989.....B44
 - G. Revision of the General Requirements Section of the
Essentials of Accredited Residencies.....B60
 - H. Revision of the ACGME Bylaws.....B62
- IV. Information Items
- A. Group Progress Reports.....B71
 - B. First Report of the Council on Graduate Medical Education.....B78

COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 22-23, 1988
Washington Hilton Hotel
Washington, D.C

PRESENT:

Board Members

Douglas E. Kelly, Ph.D.
Ernst R. Jaffe', M.D.
Frank G. Moody, M.D.
Craighead Alexander, M.D.
Lewis Aronow, Ph.D.
Joe Dan Coulter, Ph.D.
Myron Genel, M.D.
Glenn C. Hamilton, M.D.
Herbert Pardes, M.D.
Vivian W. Pinn-Wiggins, M.D.
Joel Sacks, M.D.

Staff

Catherine Cahill*
Sarah Carr*
Edwin Crocker*
Jane Donovan
Joan Hartman-Moore*
Thomas J. Kennedy, M.D.*
Jack Krakower, Ph.D.*
Dorothy Lehrman*
David Moore*
Robert G. Petersdorf, M.D.*
John F. Sherman, Ph.D.*
Allan C. Shipp*
Elizabeth M. Short, M.D.
Kathleen Turner*

Guests

John W. Colloton*
Donald Langsley, M.D., ABMS*
Thomas E. Malone, Ph.D.
Michael Rush, Ph.D., OSR
Richard S. Wilbur, M.D., CMSS*

* Attended a portion of the meeting

Wednesday, June 22, 1988
4:00 - 6:00 p.m.
Caucus Room

Dr. Kelly reviewed with the Board organizational principles and procedures which were discussed during the Executive Committee meeting.

A. The Board decided to initiate a liaison relationship between each society and an assigned board member. Assignments for 1988-89 were accepted as presented for this first year. At the end of that year, both the appropriateness of the assignments and the results of the Board's contacts will be reviewed. The Council will be surveyed in one or two years to see whether this program creates any noticeable difference for the constituency. The Board was reminded that at an upcoming Board meeting members should begin planning the orientation session for new CAS Representatives at the next Spring Meeting.

B. The recommendations of the discussion groups at the Spring Meeting were considered at length, and the Board divided itself into three subcommittees to address ways of responding to those recommendations. Dr. Kelly will chair a subcommittee charged to develop a proposal for teaching awards for biomedical education for which foundation support will be pursued. Other members of this group are Drs. Pardes, Hamilton, Pinn-Wiggins and Aronow. A subcommittee for faculty evaluation and development will be chaired by Dr. Coulter with Drs. Alexander and Jaffe'. A subcommittee to examine initiatives to address the Discontinuities in Medical Education will be chaired by Dr. Moody and Drs. Genel, Jaffe' and Sacks will participate.

Thursday, June 23, 1988
8:00 a.m. - 12:30 p.m.
Jackson Room

I. Dr. Kelly introduced Michael Rush, Ph.D., the OSR observer, as well as members of the AAMC staff.

III.A. The minutes of the last Board meeting were approved as submitted.

III.B. Dr. Jaffe' reported the slate developed by the Nominating Committee for 1989, which is as follows.

CAS Chair-Elect

Joe Dan Coulter, Ph.D.
University of Iowa
Society for Neuroscience

CAS Administrative Board (3-year terms)

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

Thornton Bryan, M.D.
University of Alabama
Association of Departments of Family Medicine

Glenn C. Hamilton, M.D.
Wright State University
Society of Teachers of Emergency Medicine

The full Council will vote on this slate at the Annual Meeting, November 14, 1988. In addition, David H. Cohen, Ph.D., Northwestern University, Society for Neuroscience, was recommended to the AAMC Nominating Committee as candidate for Chair-Elect of the Assembly.

III.C. AAMC Mission Statement and Goals

The CAS Board carefully reviewed the proposed new AAMC mission statement, and requested that changes be made as indicated below

with additions or changes underlined and deletions in parentheses.

The Association of American Medical Colleges has as its purpose the improvement of the nation's health through the advancement of academic medicine....

...into the provision of (cost-) effective health care.

Strategic Goals:

2. To promote medical education and training of high quality (consistent with the future practice of medicine).
3. To foster biomedical, behavioral and health services research and ensure an environment in which these can flourish.
6. To promote a broad(er) professional and public understanding of the contributions of academic medicine.

The Board questioned the need for Strategic Goal 5, and strongly recommended that Goal 7 be deleted.

IV.A. CAS Annual Meeting Plenary Session

The CAS will sponsor a joint plenary session at the AAMC Annual Meeting with the Council of Deans and Council of Teaching Hospitals on the subject of Misconduct in Science. The speakers will be Eleanor G. Shore, M.D., Associate Dean for Faculty Affairs at Harvard Medical School; Arthur Rubenstein, Chair of the IOM Committee on Responsible Conduct of Research; Barbara Mishkin, J.D.; and Paul J. Friedman, M.D., Associate Dean for Academic Affairs at the University of California San Diego and CAS Representative from the Association of University Radiologists.

III.D. Fraud in Research

Current AAMC activities include a joint effort with AAU, NASULGC, and CAS to draft a guide to the development of institutional policies and procedures for investigating allegations of fraud in research as a more detailed follow-up to the 1982 publication, The Maintenance of High Ethical Standards in the Conduct of Research. Staff continues to negotiate with executive and legislative branch officials in hopes of avoiding oppressive regulations or legislation.

The Inspector General's Office at the Department of Health and Human Services is examining the capability of grantee institutions in dealing with fraud cases. Ninety institutions have been surveyed by telephone and 8 or 9 site visits have been scheduled. The IG staff is gathering primarily anecdotal information, asking such questions as how many allegations have been reported, how

many times fraud guidelines have been used at specific institutions, and how procedures have been modified based on case experience. In discussing the current heightened concern in Congress about fraud in federally funded research, the Board expressed the concern that at some point accountability would begin to interfere with the ability to do research and maintenance of academic freedom. Spot inspections and spot checking of data books send messages of "no confidence" to investigators.

The Board recommended that the AAMC:

- o issue a strong condemnation of fraud and misconduct;
- o develop principles of good scientific conduct, thereby enabling a positive, proactive stance rather than a defensive one;
- o consider a Task Force to monitor and coordinate all activities in this area; and
- o undertake to quantitate instances of proven fraud in comparison to the vast scale of the biomedical research enterprise.

II. President's Report

Dr. Petersdorf asked the Administrative Board to review the qualifications for membership in the CAS. He has been contacted by the Association of Academic Health Science Library Directors who were denied CAS membership 10 years ago and want to reapply. Dr. Petersdorf acknowledged that the AAHSLD is not an exact fit with current CAS membership criteria but expressed the desire to consider where these types of educational groups fit into the AAMC.

The Board went into Executive Session with Dr. Petersdorf to discuss the proposed dues increase, and agreed to recommend to the Executive Council that the dues increase schedule, reviewed at the CAS Spring Meeting, be approved.

III.E. Physician Recredentialing

The issue for consideration was whether the Association wanted to take a position recommending periodic recertification or relicensure of all physicians and what position should be taken in regard to the Stark bill which would mandate recertification for Medicare physician reimbursement eligibility.

Only 63% of the 550,000 U.S. physicians are board certified. New York State is considering a proposal to require all physicians to meet specific standards of performance and demonstrate that these can be met every nine years. Rep. Pete Stark (D-CA) has introduced federal legislation that would require time-limited certification for all physicians who participate in Medicare. It was noted that the Stark bill places the federal government in an arena traditionally reserved for state jurisdiction. A large

portion of the 37% of uncertified physicians are rural family practitioners who serve as the only available health care in those areas. Catherine Cahill of AAMC's Office of Government Relations reported that Rep. Stark considers his legislation to be a rough draft and is looking for suggestions. There will probably be no action on the bill this year, but it is likely to be reintroduced next year.

Physician recredentialing is a very complex issue which has been extremely divisive in some specialties, and which deserves a thoughtful approach; however, if the profession does not provide leadership to address public and Congressional concerns, solutions may be legislated. The Board felt it would be premature to take a position at this time, but they were opposed to federally mandated recredentialing and to relicensure requirements as opposed to possible credentialing examinations.

ACTION: The Board voted unanimously to ask the AAMC to begin a process to develop a position on recertification after due consideration with the constituencies. This process should include consultation with other associations with the prospect of reaching a joint position.

III.F. Intramural Research at NIH

The Board was asked to consider a series of recommendations to constitute the Association's position on issues related to the organization of the NIH intramural program. The AAMC position will be transmitted to the IOM Committee examining intramural NIH status in light of an administration proposal to privatize this program. Dr. Harold Shapiro, President of Princeton, chairs this Committee and Dr. Petersdorf is a member. The Board supported the following principles as listed in the agenda: 1) assert the need for a national biomedical research laboratory such as NIH distinct from academic institutions, 2) assert that scientific excellence should be overriding in proposals to enable the program to thrive, 3) place a high priority on developing scientific manpower, and 4) consider the positive effects on the quality of extramural NIH administration derived from its intimacy with intramural NIH. Lastly, the Board felt that the AAMC should express strong reservations about privatization unless such a move would preserve and enhance the unique strengths of intramural NIH.

III.G. Institutional Policies Regarding Student Participation in Educational Experiences Involving the Use of Animals.

The Board requested that the AAMC conduct a survey to see how many schools have policies addressing student participation in educational exercises using animals. Several schools have stated in their admissions materials that animals may be used in medical education and that the student should not accept admission if s/he cannot comply with these educational requirements. The Board agreed that the AAMC should reissue the memorandum of

May 1, 1987, encouraging schools to articulate policies on the use of animals in medical education.

III.H. Revision of ACGME General Requirements

ACGME has proposed to its five parent organizations that Section 3.5, Paragraph 2, be reworded to more strongly urge participation in the NRMP match by all approved residency programs. The words "...are strongly encouraged to..." would be changed to "should". Discussion ranged from concerns that this gesture would merely exacerbate an already regrettably tense relationship between AAMC, NRMP, and those specialties using non-NRMP matches, to questions of whether this wording change had any substantive meaning. It was noted that an ad hoc committee chaired by Dr. Richard Wilbur will be evaluating the role and future of the NRMP and that this is a time when strong encouragement should be given to NRMP and the specialties using other matches to work out their differences and better coordinate the match process.

ACTION: The Board approved the ACGME proposed revision by a vote of 9 in favor, one opposed and one abstention.

IV.B. Group Progress Reports to the Executive Council

These reports were acknowledged and the report of the Group on Medical Education was especially called to the Board's attention because of recent efforts to increase faculty participation in this group. The Board dissolved into the three subcommittees dealing with the recommendations of the discussion groups from the Spring Meeting.

REPORT
COUNCIL OF ACADEMIC SOCIETIES
NOMINATING COMMITTEE

July 28-29, 1988

Committee Members

Ernst R. Jaffe', M.D., Chairman
Douglas E. Kelly, Ph.D.
Stanley Schultz, M.D.
Beverley Rowley, Ph.D.
William Drucker, M.D.
Thomas King, M.D.
Eleanor Z. Wallace, M.D.

Staff

Jane Donovan

The CAS Nominating Committee was polled by telephone on July 28 and 29 to select a nominee for the At-Large Executive Council member from the Council of Academic Societies. The CAS is allotted 4 members on the Executive Council: the Chair, Chair-Elect, Immediate Past-Chair, and one At Large member. The past 6 years the At Large position has been filled by W. F. Ganong, M.D.

S. Craighead Alexander, M.D. was selected by the Nominating Committee. The full AAMC Assembly will vote on this nomination on November 14, 1988 at the Annual Meeting in Chicago.

CAS NOMINATION FOR DISTINGUISHED SERVICE MEMBER

In June 1980 the CAS Administrative Board established a policy whereby an individual would automatically be considered for nomination to the category of Distinguished Service Member in the AAMC if s/he has served as chairman of the CAS, chairman of the AAMC representing the CAS, or as a member of the CAS Administrative Board for two consecutive terms. Accordingly, the CAS Board should consider:

Frank G. Moody, M.D.
William F. Ganong, M.D.

CAS Chairman, 1986-87
CAS Administrative Board member,
1979-1988

The sections of the AAMC Bylaws pertaining to Distinguished Service Membership and the current list of Distinguished Service Members from the CAS are shown below for reference.

AAMC Bylaws

- I.2.B - "Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1."
- I.3.E - "Distinguished Service Members shall be recommended to the Executive Committee by either the Council of Deans, Council of Academic Societies, or Council of Teaching Hospitals."

CAS Distinguished Service Members

Robert M. Berne
F. Marian Bishop
A. Jay Bollet
Samuel L. Clark, Jr.
Carmine D. Clemente
David H. Cohen
Jack W. Cole
Ludwig W. Eichna
Ronald W. Estabrook
Harry A. Feldman
Patrick J. Fitzgerald
Robert E. Forster, II

Daniel X. Freedman
Robert L. Hill
Rolla B. Hill, Jr.
Ernst Knobil
John I. Nurnberger
Thomas K. Oliver
Hiram C. Polk
Jonathan E. Rhoads
James V. Warren
Ralph J. Wedgwood
William B. Weil, Jr.
Virginia V. Weldon
Frank C. Wilson

Rules and Regulations
of the Council of Academic Societies

Section I. Members

1. Academic Societies active in the United States in the professional fields of medicine and biomedical sciences which have special interests in advancing medical education may be nominated for election to membership in the Association of American Medical Colleges by a two-thirds vote of the Society Representatives at a duly constituted meeting of the Council of Academic Societies, provided that notice of the proposed nomination shall have been given to the Representatives of the Member Societies at least thirty (30) days in advance of the meeting. The names of Societies so nominated shall be recommended to the Executive Council of the Association of American Medical Colleges for election to membership therein by the Assembly of the Association.

2. Individuals with a special competence or interest in advancing medical education may be nominated by the Council for membership in the Association of American Medical Colleges using the same procedure as set forth above for nomination of Member Societies. Individuals so elected to membership in the Association of American Medical Colleges shall be members-at-large of the Council of Academic Societies.

3. Resignation or revocation of membership. Resignation or revocation of membership in the Council of Academic Societies shall be in accordance with the Bylaws of the Association of American Medical Colleges, and no society or individual who is not a member of the Association of American Medical Colleges shall be a member or member-at-large of the Council of Academic Societies.

From the AAMC Bylaws:

I. MEMBERSHIP

Section 1. There shall be the following classes of membership:....

G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.

Objectives of the Council of Academic Societies: (p. 1, 1988 CAS Directory)

1. Provide a forum for the expression of faculty concerns and opinions, and;
2. Enhance faculty participation in the formulation of national policy related to medical education, research, and patient care.

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 22-23, 1986
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

David H. Cohen, Chairman
Joe D. Coulter
William F. Ganong
Gary W. Hunninghake
Ernst R. Jaffe
A. Everette James, Jr.
Gordon I. Kaye
Douglas E. Kelly
Jack L. Kostyo
Frank G. Moody
Virginia V. Weldon

Staff

David Baime*
Melissa Brown*
Christine T. Burris
John A. D. Cooper*
Carolyn Demorest
Joseph A. Keyes, Jr.*
David B. Moore
James Schofield*
John F. Sherman*
Elizabeth M. Short
August G. Swanson*
Kathleen Turner*

Guests

Richard Janeway*
Edward J. Stemmler*

* Present for part of meeting

- I. The CAS Administrative Board met at 4:30 p.m. Wednesday, January 22, 1986, for an informal discussion of several issues related to representation in the Council of Academic Societies. Dr. Cohen noted that this discussion was prompted, in part, by the continued proliferation of societies seeking membership in the Council and by a growing number of complaints with respect to the representation of societies on the Administrative Board. He said that there were three main questions to be addressed: should the criteria for Council membership be changed, how should member societies be represented within the Council, and how should the members of the Administrative Board be selected?

The general consensus among Board members was that the CAS should be broadly representative of the faculty at academic medical centers; therefore, the criteria for membership should remain relatively open. Two possible dangers were identified with open admission: development of a duplicate constituency and inclusion of non-academic groups. A duplicate representation was thought to be problematic only in terms of the governance of the Council, but because the Council rarely, if ever, takes formal votes on issues, this was not seen as a prohibitive problem. The Board was unable to determine a crisp a priori definition of an academic society for use as an admission criterion; therefore, it was decided that the Board would continue to deal with the question of whether a society is "academic" on a case-by-case basis at the time of the society's application for membership.

With respect to the representation of the individual member societies within the Council, it was felt that the current public affairs and legislative issues facing faculty are inseparable from other academic issues. The Board therefore recommended discontinuation of the office of Public Affairs Representative (PAR). It was decided that each society would continue to have two representatives; however, the Board recommended that the Rules and Regulations should be amended to leave the length of the term for CAS representatives to the discretion of the individual societies. Guidelines would be provided to the societies suggesting that at least one representative have a term sufficient to develop expertise with the issues of importance to the Council and the Association.

It was agreed that the most important consideration in selecting members for the Administrative Board should be the quality of the individuals. As a result, the Board recommended that the current custom of maintaining a 6:6 ratio of basic scientists to clinicians be replaced with a more flexible system with a minimum of 4 basic scientists and 4 clinicians on the Board. This would facilitate the selection of the best possible representative for service on the Board. The Board also recommended an explicit information campaign related to the representation on the Board, and suggested that the CAS Nominating Committee solicit recommendations from the society representatives for nominees for the Board prior to the Committee's conference call in May.

Societies whose membership applications have been rejected by the CAS

1. American College of Legal Medicine

The ACLM was turned down twice, in September 1982 and again in January 1986. They failed to meet the requirement of emphasis on medical education and research, particularly as they occur in the academic medical center. Although ACLM has a medical orientation and primarily MD membership, its focus seemed to be on medical practice issues rather than on medical education. Additionally, although approximately 40% of ACLM members hold faculty appointments, a substantial number of those are law school positions instead of medical school positions.

2. American Society for Aesthetic Plastic Surgery

The ASAPS did not meet the legal tax status requirements of the AAMC.

3. Society of Medical Consultants to the Armed Forces

SMCAF did not meet the legal tax status requirements of the AAMC.

4. Society of Medical College Directors of Continuing Medical Education

At the 1982 Council of Deans Spring Meeting, a resolution was adopted by unanimous vote that the proper mechanism for SMCDCME to interact with the AAMC is through membership and participation in the Group on Medical Education. The CAS Administrative Board voted not to accept the SMCDCME application for CAS membership on the recommendation of the Deans, and advised the SMCDCME that their membership appeared to be administrators, not faculty, and therefore would be inappropriate for CAS membership.

In April 1988 SMCDCME expressed interest in reapplying on the grounds that a high percentage of their members now hold faculty appointments, and their continued belief that the CAS is an appropriate affiliation for this group. We have not received a formal application from them at this time.

5. Association of Academic Health Sciences Library Directors

In April 1977, Gerald Oppenheimer, Assistant Director of Health Science Libraries at the University of Washington, asked the AAMC to establish a formal section on medical school libraries. This request was denied due to limited AAMC resources, and Oppenheimer was encouraged to form a disciplinary society of medical school libraries and apply for CAS membership. The AAHSLD was duly formed, held its first meeting in June 1978, and applied for CAS membership immediately thereafter. Their application was denied by the CAS Administrative Board because the AAHSLD's primary mission is service and support of the various groups that comprise the CAS, and that they do not have direct input into the medical education process. In June 1988, representatives of the AAHSLD met with Dr. Petersdorf regarding their continuing interest in CAS membership. It was as a result of that meeting that Dr. Petersdorf asked the CAS Administrative Board to review CAS membership criteria with an eye toward advising AAHSLD whether a new application from them would be positively received.

August 12, 1988

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: Society of Medical College Directors of Continuing
Medical Education

MAILING ADDRESS: c/o Dr. George J. Race, Secretary/Treasurer
The Univ. of Texas Health Science Center at Dallas
5323 Harry Hines Blvd.
Dallas, Texas 75235

PURPOSE: To establish the national forum for the Society of Medical College Directors of Continuing Medical Education. To improve patient care through continuing medical education. To study the important issues in continuing medical education and to formulate positions on them. To facilitate the exchange of continuing medical education-related knowledge helpful to the membership in their individual roles. To encourage basic research in areas related to continuing medical education and physicians' competence, and to assist in disseminating the results of such research. To aid in establishing linkages with other disciplines of importance to continuing medical education's mature development. To encourage professional exchanges with other institutions and organizations involved in continuing medical education. To engage in such other activities deemed appropriate to fulfill the purposes of the society.

MEMBERSHIP CRITERIA: Any director of C.M.E. of any medical college accredited by the Liaison Committee on Medical Education is eligible for voting membership (Sec. 1, Art. III). Any associate director of Continuing Medical Education of any medical college accredited by the Liaison Committee on Medical Education is eligible for associate membership.

(Sec. 2, Art. III)

NUMBER OF MEMBERS: 159

NUMBER OF FACULTY MEMBERS: 125

DATE ORGANIZED: April 2, 1976

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

Adopted April 2, 1976

Revised Oct. 22, 1978

Revised March 17, 1980 1. Constitution & Bylaws

October 26, 1980

March 17, 1980 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

From the Association of Academic Health Sciences Library Directors application for CAS membership in 1987:

PURPOSE: A medium for communication among directors of academic health sciences libraries to address their common concerns of planning, program and policy development, to extend their contacts nationally, and to provide a forum for joint action.

OBJECTIVES: Investigate the status of academic health sciences libraries concentrating on their general conditions of existence, and to make recommendations, as appropriate, to correct deficiencies at the national level, and to take action, where feasible, to improve these conditions to enhance their capabilities to render support to their parent institutions. Specifically, this would touch on such areas as increasing the effectiveness of the library in relation to health sciences educational programs, joint planning in the development of curricula, and the improvement of the libraries' services and staff. Clarify the status of member libraries. Develop positive papers about funding support, whether from private, state or Federal sources. Establish close cooperation with such related organizations as the Association of American Medical Colleges, the Medical Library Association, the National Library of Medicine, and similar institutions and organizations for mutual support and improvement of programs.

REGULAR MEMBERS: Regular members shall be educational institutions (or division, department, or section thereof which is an academic health sciences library) which are either (a) organizations exempt from Federal income taxation under section 115(a) of the Internal Revenue Code of 1954 or (b) organizations exempt from Federal income tax under Section 501(a)(1), (2) or (3) of said Code (or the corresponding provisions of any future United States internal revenue law).

ASSOCIATE MEMBERS: Associate members shall be individuals and organizations having an interest in the purposes and activities of the Corporation. Associate members shall not be eligible to vote and shall not be able to hold office in the Corporation.

MEMBER REPRESENTATIVES: Each Regular Member of the Corporation shall be represented at its meetings by the Chairman or other administrative head of such member's academic health sciences library (or department, division or section, as the case may be). Each Associate Member which is an organization shall be represented by its Chairman or other administrative head.

NUMBER OF MEMBERS: 125

NUMBER OF FACULTY MEMBERS: unknown