



**COUNCIL OF ACADEMIC SOCIETIES**

**SPRING MEETING  
APRIL 10 - 11, 1984**

**Status Report: Issues of Interest to Faculty**

AAMC Statement of Principles for the Support of Biomedical Research . . . . . 1

FY 1985 Budget . . . . . 2

Other Budget Activity . . . . . 9

NIH Reauthorization Legislation . . . . . 10

Fetal Research Legislation . . . . . 11

Proposed NIH Institute of Nursing . . . . . 12

Issues Related to the Use of Animals in Research . . . . . 13

Research Roundtable . . . . . 16

Specialty Residency (PGY 2) Match of Medical Students . . . . . 17

Status of Student Assistance Programs . . . . . 18

Small Business Competition for Federal Contracts . . . . . 19

Status of Research Facilities and Instrumentation . . . . . 21

Indirect Costs on NIH Research Grants . . . . . 25

Proposed Changes in Medicare Reimbursement Policies . . . . . 27

Nondiscrimination on the Basis of Handicap: "Baby Doe" . . . . . 29

Organ Transplant Legislation . . . . . 31

Low-Level Nuclear Waste Disposal . . . . . 32

Hazardous Waste Legislation . . . . . 34

Social Security Advisory Council Recommendation Regarding Medical Education Expenses . . . . . 35

## AAMC STATEMENT OF PRINCIPLES FOR THE SUPPORT OF BIOMEDICAL RESEARCH

At meetings held in the summer of 1983, the Association's governing boards perceived the need to articulate the basic principles which should govern the funding and management of the National Institutes of Health. Such a statement was developed and adopted by the CAS Administrative Board and the AAMC Executive Council in September. The thrust of the document\* is summarized in the points outlined below:

- that research priorities are best set by the NIH and its scientific advisors
- that Congressional mandates in authorizing legislation are an undesirable mechanism for achieving special attention for specific research areas
- that the open-ended NIH authority provided in Section 301 of the Public Health Service Act has served science and the nation well

The document will be used to generate strong support for the NIH and to highlight the dangers of Congressional "micromanagement" of NIH programs.

The statement was sent to the presidents and public affairs representatives of all CAS societies with a request that they consider adopting it as a formal position of their organization. Clearly, endorsement of the document by CAS societies will enhance its impact.

To date, the following organizations have adopted the statement:

Association of Anatomy Chairmen  
Association of University Anesthetists  
Society of Academic Anesthesia Chairmen  
American Society of Biological Chemists  
Association of Medical School Departments of Biochemistry  
American Federation for Clinical Research  
Endocrine Society  
Association of Professors of Medicine  
American Academy of Neurology  
Association of University Professors of Neurology  
Society for Pediatric Research  
Association of Medical School Pediatric Department Chairmen  
Association of University Radiologists

Representatives of societies not listed above are encouraged to contact the presidents of their societies to urge that their organization's governing boards consider formal adoption of the statement.

\* copies are available at the registration desk

## FY 1985 BUDGET

### National Institutes of Health and Alcohol, Drug Abuse and Mental Health Administration

The President has proposed an FY 1985 budget that includes increases over FY 1984 funding levels of \$89 million (2%) for the National Institutes of Health (NIH) and \$17 million (4.6%) for the research activities of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Adoption of the President's budget would:

- Allow merely 30 percent of approved projects at NIH, and 36 percent at ADAMHA, to be funded, resulting in the inability to fund proposals rated by peers at high levels of excellence.
- Require cuts in the direct costs of both competing and non-competing grants, for the third successive year, contracting the scope of science that could be undertaken.
- Reduce the number of NIH and ADAMHA research trainees to 9,982-- a further decline from the FY 1983 level of 11,650--rejecting a National Academy of Sciences recommendation for 12,195 trainees. This would cause long term and serious damage to the nation's supply of well-trained research scientists.
- Support only 1 major new clinical trial, compared to 19 new starts in FY 1984, impeding the application of discoveries to patient care.
- Preclude renovation of badly deteriorating physical plants and severely limit funds for laboratory equipment across the nation, slowing the discovery of new knowledge.
- Reduce, by more than 600 persons, the research, services and support staffs at NIH and ADAMHA with threatening consequences, particularly for the intramural research program.

For the past two years, a consortium of as many as 140 organizations has joined together to advocate adequate funding for biomedical and behavioral research. This coalition has been extremely successful and, given the inadequate levels of support proposed by the Administration for FY 1985, a similar effort is being coordinated this year.

A proposal has been developed by an Ad Hoc Group of staff from a number of key organizations including the AAMC. It advocates minimum increases of \$647 million and \$41 million over the President's request for the NIH and ADAMHA respectively. The activities to be supported by the additional funds are itemized on pages 4-5. (The coalition's proposal focusses only on the research and research training programs of the NIH and ADAMHA. Therefore, the Administration's proposed reduction in non-research activities of ADAMHA are not addressed. They include the elimination of the agency's clinical training programs--funded at a level of \$21 million in FY 1984--and the Community Support Program--funded at a level of \$7 million in FY 1984.)

The proposal, with a request for support, was circulated to all CAS societies. To date over 100 organizations including many CAS societies (see pages 6-8) have endorsed the Ad Hoc Coalition's recommendations. There is still time for societies to sign on in support of the proposal. Representatives of societies

not listed are encouraged to contact the presidents of their societies to urge that their organization formally endorse the proposal.

Veterans Administration

The budget for the Veterans Administration's medical care represents almost a 7% increase. VA research as a whole would decrease but this includes a significant cut in funding for an Agent Orange epidemiological study. Discounting for this, medical research would increase by about 11% education and training would increase by 4%.

	(in millions)		
	<u>FY 1983</u> <u>Actual</u>	<u>FY 1984</u> <u>Estimate</u>	<u>FY 1984</u> <u>Budget Request</u>
<u>Medical Care</u>			
Education and Training	7,773.3 (413.0)	8,204.4 (435.8)	8,767.4 (453.4)
<u>Medical and Prosthetic Research</u>			
Medical Research	141.1	201.7 <sup>1</sup>	172.6 <sup>2</sup>
Rehabilitative Research	10.0	10.9	14.1
Health Services Research	3.8	5.1	6.0
Subtotal Research	<u>154.8</u>	<u>217.7</u>	<u>192.7</u>

/1 Reflects \$54 million for Agent Orange study  
 /2 Reflects \$8.6 million for Agent Orange study

## Ad Hoc Group for Medical Research Funding: A proposal for the National Institutes of Health

FY 1984 Appropriation	President's FY 1985 Request	Ad Hoc Group's FY 1985 Recommendation	Recommendation Over FY 1984	Recommendation Over FY 1985 Request
\$4.477 billion	\$4.567 billion	\$5.214 billion	16%	14%

*"Biomedical research today determines medical practice tomorrow."*

Donald S. Fredrickson, M.D.  
"Health and the Search for Knowledge"; *Daedalus* Winter 1977.

This proposal brings the increase for the NIH into line with those requested by the President for science support in other agencies. (Figure 1)

### **In contrast to the President's request, our proposal provides:**

- Funds sufficient to make awards to a minimum scientific priority score of 185 or at least 37% of approved research grant applications, although higher levels may be necessary in some Institutes (+ \$184 million). Even this request would fund only a portion of the estimated 2,200 excellent (priority scores to 200) grant applications that would go unfunded under the President's request. (Figures 3 and 4)
- Funding of research projects at study-section recommended levels. (+ \$138 million)
- Expansion in research career awards, directed at encouraging young clinicians to enter into research careers. (+ \$14 million)
- Research training for the number of NIH trainees (10,518) recommended by the National Academy of Sciences, with stipends increased to more reasonable levels. (+ \$64 million)
- Opportunities to initiate additional high priority major clinical trials; to increase biotechnology programs in order to capitalize on the enormous challenges presented by technological progress in instrumentation, techniques and systems; and to provide a small start on the upgrading of facilities for laboratory animals. (+ \$32 million)
- An increase in the Biomedical Research Support program to support promising young scientists, to fund pilot projects and to enlarge the shared instrumentation program. (+ \$44 million)
- An increase in research facility construction funds, to highlight the reality that federal assistance for this activity has been delayed for a decade and a half, and that the national research plant is outmoded and increasingly inefficient. (+ \$20 million)
- Maintenance levels for the remainder of the research programs including centers, contracts, minority biomedical research support, intramural research, and the National Library of Medicine and elimination of the proposal to cut NIH personnel. (+ \$151 million)

**Total: \$647 million over the President's request**

# Ad Hoc Group for Medical Research Funding: A proposal for the Alcohol, Drug Abuse and Mental Health Administration Research and Research Training Activities

FY 1984 Appropriation	President's FY 1985 Request	Ad Hoc Group's FY 1985 Recommendation	Recommendation Over FY 1984	Recommendation Over FY 1985 Request
\$356 million	\$373 million	\$414 million	16%	11%

*'Recent advances in brain research have put us in the midst of the most exciting era since the dawn of the space age.'*

Michael Phelps, Ph.D.; UCLA  
quoted in *The Wall Street Journal* December 19, 1983

Our proposal takes advantage of and builds upon the extraordinary findings that are emerging from recently supported research. The increase for ADAMHA research and research training activities is in line with those requested by the President for science support in other agencies. (Figure 1)

### **In contrast to the President's request, our proposal provides:**

- Funds sufficient to make awards to a minimum scientific priority score of 183 or at least 43% of approved research grant applications (+ \$13 million). Even this request would fund only a portion of the estimated 225 excellent (priority scores to 200) grant applications that would go unfunded under the President's request. (Figures 3 and 4)
- Funding of research projects at study-section recommended levels. (+ \$8 million)
- Expansion in Research Scientist awards with special emphasis on clinical researchers. (+ \$3 million)
- Support for approximately 1,300 research trainees, a necessary step to assure the future availability of well-trained men and women upon whom the nation depends for the success of the research effort. Stipends increased to more reasonable levels. (+ \$8 million)
- Restoration of positions proposed for elimination in the intramural program, to assure the maintenance of a continued level of effort in ongoing research programs. (+ \$3 million)
- Funding for research centers, cooperative agreements and contracts, important components in the total research effort, at slightly higher levels. (+ \$3 million)
- Maintenance levels for the remainder of the important direct operations and program management functions associated with the research program. (+ \$3 million)

**Total: \$41 million over the President's budget**

APRIL 3, 1984

ORGANIZATIONS SUPPORTING THE AD HOC GROUP PROPOSAL FOR HEALTH  
RESEARCH FUNDING IN FY 1985

Academy of Clinical Laboratory Physicians and Scientists  
Alzheimer's Disease and Related Disorders Association  
American Academy of Allergy and Immunology  
American Academy of Child Psychiatry  
American Academy of Dermatology  
American Academy of Neurology  
American Academy of Orthopaedic Surgeons  
American Academy of Otolaryngology and Head and Neck Surgery  
American Academy of Pediatrics  
American Association for Dental Research  
American Association for the Study of Liver Disease  
American Association of Anatomists  
American Association of Colleges of Osteopathic Medicine  
American Association of Colleges of Pharmacy  
American Association of Dental Schools  
American Association of Neurological Surgeons  
American Association of Pathology  
American Association of University Professors  
American College of Chest Physicians  
American College of Neuropsychopharmacology  
American Council on Education  
American Diabetes Association  
American Federation for Aging Research  
American Federation for Clinical Research  
American Gastroenterological Association  
American Geriatric Society  
American Heart Association  
American Institute of Biological Sciences  
American Lung Association/American Thoracic Society  
American Psychiatric Association  
American Urological Association  
American Society for Cell Biology  
American Society for Clinical Investigation  
American Society for Clinical Pharmacology and Therapeutics  
American Society for Developmental Biology  
American Society for Gastrointestinal Endoscopy  
American Society for Pharmacology and Experimental Therapeutics  
American Society of Clinical Oncology  
American Society of Hematology  
Associated Medical Schools of New York  
Association for the Behavioral Sciences and Medical Education  
Association for Medical School Pharmacology  
Association of Academic Surgery  
Association of American Cancer Institutes  
Association of American Medical Colleges  
Association of American Physicians  
Association of American Universities

Association of Anatomy Chairmen  
Association of Chairmen of Departments of Physiology  
Association of Directors of Medical Student Education in  
Psychiatry  
Association of Independent Research Institutes  
Association of Medical School Departments of Biochemistry  
Association of Medical School Microbiology Chairmen  
Association of Medical School Pediatric Department Chairmen, Inc.  
Association of Neuroscience Departments and Programs  
Association of Orthopaedic Chairmen  
Association of Professors of Dermatology, Inc.  
Association of Professors of Medicine  
Association of Program Directors in Internal Medicine  
Association of Schools of Public Health  
Association of University Anesthetists  
Association of University Professors of Neurology  
Asthma and Allergy Foundation of America  
Central Society for Clinical Research  
Citizens Committee for Medical Research and Health Education  
Coalition for Health Funding  
Congress of Neurological Surgeons  
Cooley's Anemia Foundation  
Council of Graduate Schools  
Council on Social Work Education  
Cystic Fibrosis Foundation  
Delegation for Basic Biomedical Research  
Dystrophic Epidermolysis Bullosa Research Association of  
America  
Epilepsy Foundation  
Federation of American Societies for Experimental Biology  
Friends of Eye Research  
Friends of Health  
Infectious Disease Society of America  
Immune Deficiency Foundation  
Joint Committee on Health Policy  
Juvenile Diabetes Foundation  
Lupus Foundation of America  
March of Dimes  
Medical Library Association  
National Alliance for the Mentally Ill  
National ALS Foundation  
National Association of State Universities and Land-Grant  
Colleges  
National Committee for Research in Neurological and Communicative  
Disorders  
National Foundation for Infectious Diseases  
National Hemophilia Foundation  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Parkinson Foundation, Inc.  
National Psoriasis Foundation  
National Society for Medical Research  
National Spinal Cord Injury Association  
National Tuberos Sclerosis Association  
Orthopaedic Research Society  
Plastic Surgery Research Council



Public and Scientific Affairs Board of the American Society for  
Microbiology  
Renal Physicians Association  
Society for Gynecologic Investigation  
Society for Health and Human Values  
Society for Investigative Dermatology  
Society for Neuroscience  
Society for Pediatric Research  
Society of Teachers of Emergency Medicine  
Society of University Surgeons  
Southern Society for Clinical Investigation

## OTHER BUDGET ACTIVITY

House: The House Budget Committee has marked up its version of the First Concurrent Budget Resolution, the vehicle for setting spending targets for FY 1985. The Committee has approved a plan for a freeze on discretionary domestic spending--which includes discretionary health programs--at a level 3.5% over the FY 1984 level, a drop in constant dollar terms. Within this, it appears that there will be a good deal of flexibility in the actual appropriation of funds for various programs. The Budget Resolution is currently under consideration on the floor of the House where eight substitute amendments are on the table.

The House is holding the proposals formulated for reconciliation of the FY 1984 budget (The Tax Reform Act of 1984) and the now separate spending reductions, including Medicare and Medicaid proposals, for application in the FY 1985 reconciliation process.\*

Senate: Work is proceeding on S.2062, the Omnibus Reconciliation Act of 1983, and amendments regarding spending guidelines for FY 1985 may well be attached to that measure.\* However, this possibility has raised numerous procedural questions. The Senate GOP idea for FY 1985 is an across-the-board freeze for nondefense discretionary programs at FY 1984 levels with Medicare and Medicaid reduced by \$14.7 billion over a three year period.

\* See pages 27-28

## NIH REAUTHORIZATION LEGISLATION

The purpose of this legislation is to renew the expiring authorities of the NCI, NHLBI, the National Research Service Awards program, and the National Library of Medicine. (The remaining institutes operate under the open-ended authority provided in Section 301 of the Public Health Service Act.) However, once again, the legislation is being used as a vehicle for special interests and both the House and Senate versions contain numerous set asides and disease-specific provisions. The Administration and representatives of the research community have expressed serious concerns regarding the distortion of the purpose of the legislation.

House: The NIH renewal bill (H.R. 2350) passed by the House of Representatives last fall represented a compromise between the original bill, sponsored by Representative Henry Waxman (D-Ca), and a substitute bill offered by Representatives Richard Shelby (D-Al), Edward Madigan (R-Ill), and James Brody (R-Nc). While the House-passed compromise is a considerable improvement over the original version, it does contain some troublesome provisions including: the establishment of two new institutes (one for arthritis, the other for nursing\*); the creation of multiple committees and task forces; set asides for research in specified areas; and language regarding fetal research.+ The bill provides for the renewal of the expiring NIH authorities at a level 10% above the President's FY 1984 budget request plus allowance for inflation.

Senate: Although it is neither as rigid nor as broad in scope as the House version, the Senate bill (S. 773) does contain some specific directives including: the establishment of four new interagency coordinating committees; creation of a digestive disease clearinghouse and data system; and the establishment of an arthritis institute. The bill provides for the renewal of the expiring NIH authorities at a level 5% above the President's FY 1984 budget request.

Senator Jeremiah Denton (R-Al) is expected to sponsor an amendment to the bill that would severely restrict fetal research activity. Because he opposes such an amendment, Senator Robert Packwood (R-Or) has placed a "hold" on the bill to delay floor action. Therefore, it is unclear when, or if, the legislation will be considered.

Fortunately, absent passage of this renewal legislation by both houses, funding for the NCI and the NHLBI can be provided under the open-ended Section 301 authority. However, such is not the case for the NRSA program and the library assistance program which must be authorized separately. For FY 1984, funds for these activities are provided under a continuing resolution at the FY 1983 levels. It is unclear how the HHS appropriations subcommittees will elect to fund these programs in FY 1985 if the necessary authorizing legislation has not been passed by the end of this session.

\*see page 12

+see page 11

## FETAL RESEARCH LEGISLATION

House: The NIH renewal bill (H.R. 2350)\* contains language regarding the conduct of fetal research. Representative William Dannemeyer (R-Ca) offered a floor amendment stating that:

"The Director of NIH and the director of any national research institute may not conduct or support research or experimentation, in the United States or abroad, on a living human fetus or infant, before an abortion which the researcher involved knows or has reason to know is intended or after an abortion, unless the research or experimentation is for the purpose of improving the probability of the survival of, or ameliorating developmental or congenital defects in, such infant."

Representative Henry Waxman (D-Ca) spoke against the amendment, noting that the Secretary of HHS has indicated that current regulations "provide necessary and appropriate safeguards for the conduct of fetal research." However, the Dannemeyer amendment was accepted. Subsequently, Representative Rodney Chandler (R-Wa) offered an amendment that would allow fetal research to be conducted if the risk to the fetus is minimal and the knowledge to be gained from the experimentation cannot be obtained through other means. It remains unclear whether the Chandler amendment supersedes the total restriction on fetal research advocated by Mr. Dannemeyer.

Senate: Senator Jeremiah Denton (R-AI) is expected to sponsor an amendment, similar to the Dannemeyer language, when the Senate NIH reauthorization bill\* is considered on the floor.

\* see page 10

## PROPOSED NIH INSTITUTE OF NURSING

House: The House-passed NIH renewal bill (H.R. 2350)\* includes a provision to establish an institute of nursing within NIH. Representative Edward Madigan (R-Il) offered the proposal as an amendment to H.R. 2350 during floor debate. Representatives Carl Pursell (R-Mi), George O'Brien (R-Il), Philip Crane (R-Il), and Henry Waxman (D-Ca) spoke in favor of the amendment. It passed on the House floor without objection.

Senate: Senator Daniel Inouye (D-Hi) has circulated a letter to every member of the Senate indicating his plans to introduce separate legislation "in the near future" that would establish an institute of nursing at NIH. It may be that he intends to offer the proposal as an amendment to the Senate NIH renewal bill (S. 773)\* when it is brought to the floor for a vote.

If the proposal is brought to the Senate floor, it is likely to be passed. It is hoped that the Senate will defer action on the proposal in light of several considerations:

- An Institute of Medicine Committee on the NIH Organizational Structure will be issuing its report in the fall. The Committee is giving specific consideration to the advisability of establishing an institute of nursing.
- A Task Force of the Public Health Service has been charged to consider various options for elevating the status of nursing research within the PHS, perhaps including: a center in the Office of the Assistant Secretary for Health; a bureau within the Health Resources and Services Administration, the agency which currently supports nursing research through its Division of Nursing; an independent bureau of the PHS; and the expansion of the nursing research activity of the National Center for Health Services Research. This Task Force is expected to issue recommendations by the end of the year.
- The Director of the NIH is in the process of establishing a task force to review past and current NIH activities in the area of nursing research. In addition, potential areas for increased support for nursing research will be explored and evaluated within the context of the NIH mission.

In addition, it is hoped that Congressional hearings will be held to allow interested parties, including NIH administrators, to express their views regarding so significant a change in the NIH organizational structure. (Hearings were not held in the House.)

\* see page 10

## ISSUES RELATED TO THE USE OF ANIMALS IN RESEARCH

### Legislation

Senate: The latest version of S. 657, "The Improved Standards for Laboratory Animals Act" sponsored by Senator Robert Dole (R-Ks), would require:

- an upgrading of the standards of the Animal and Plant Health Inspection Service (APHIS)
- the establishment of institutional "animal committees" (including a veterinarian and an individual "primarily responsible for representing community concerns regarding the welfare of animal subjects") to make semi-annual inspections and assure compliance with APHIS standards
- annual sessions (sponsored by institutions) for those involved in the handling of laboratory animals to provide instruction in: 1) the humane practice of animal maintenance and experimentation, and 2) ways to limit the use of animals and minimize animal pain and distress

Senator Dole may offer his bill as an amendment to the Senate NIH renewal bill (S. 773)\* when it is considered on the floor.

Senators Orrin Hatch and Edward Kennedy have introduced S. 964, "The Animal Research Study Act of 1983," which would require a study of the use of animals in research: the numbers and types of animals, an analysis of the manner in which they are used, the extent to which research facilities can assure humane treatment, and incentives for the development of alternative methods. The study is also a provision of the Senate NIH renewal bill. Many in the research community have advocated the study of the use of animals as a precursor of appropriate legislation.

House: The House-Passed NIH renewal legislation (H.R. 2350)\* includes an amendment regarding the use of animals in research which represents a substantial compromise over the language originally offered by Representative Doug Walgren (D-Pa). (There is no provision for the accreditation of laboratory facilities.) The bill now proposes:

- a study of the use of animals in research (similar to that proposed by Senators Hatch and Kennedy)
- the establishment of institutional animal care committees (Reporting requirements are reduced over the original version and language suggesting that the committees should make judgments regarding research methods was removed.)
- a plan for the development of alternative methods (rather than the specific authorization originally proposed)
- the establishment of guidelines (as opposed to the regulations originally proposed) regarding the use of animals (Since the NIH already has guidelines regarding the care of laboratory animals, this provision essentially mandates the status quo.)

Clearly, the research community was effective in its opposition to Mr. Walgren's proposals.

\* see page 10

H.R. 5098, introduced on March 8 by Representative Robert Torricelli, is based on a "model bill" developed by United Action for Animals. The goals of this bill, entitled the "Information Dissemination and Research Accountability Act," are stated to be: 1) the prevention of "duplicative experimentation or testing on live animals" and 2) the promotion of "the advancement and use of modern technologies with respect to the storage and dissemination of biomedical information. The major provisions of the bill are:

- the establishment of a National Center for Research Accountability within the National Library of Medicine "to assist in eliminating duplication of effort in Federal research proposals involving live animals" (The bill states that if the Center determines that a proposal "is essentially duplicative of other research completed or in process, no Federal funding may be utilized with respect to such project.")
- "the modernization of biomedical information storage and dissemination by the National Library of Medicine"

The bill has been referred to the Committee on Energy and Commerce. Having battled recently over the Walgren proposal (see page 13), the Committee is not likely to consider the Torricelli bill in the near future.

#### Outcome of Conference on Department of Defense Appropriations Bill

In November, House and Senate conferees on the FY 1984 Department of Defense Appropriations bill agreed to prohibit the purchase of "dogs and cats for the purpose of training DOD students or other personnel in surgical or other medical treatment of wounds produced by any type of weapon." By adopting the Senate language (dogs and cats), the conferees in effect rejected the House version which specified that no "animals" be purchased for this purpose. (Currently, dogs and cats are not used for "training.") Originally, it was Senator Daniel Inouye (D-Hi) who offered an amendment to change the provision so as to specify dogs and cats rather than animals generally. (Senator Inouye tried unsuccessfully to delete the clause completely.) The efforts of many CAS societies were instrumental in assuring that the House version was rejected in favor of the less troublesome Senate language. This victory is particularly noteworthy in light of the fact that animal rights activists were voicing strong support for the House language.

#### OTA Study

The Office of Technology Assessment has initiated a project to examine the acquisition and use of animals in toxicity testing and biomedical research. An advisory panel appointed to oversee the project will also consider the feasibility and cost of developing technologies to substitute for laboratory animals. The ethical issues related to animal research will also be examined in an effort to clarify the reasons for the controversy surrounding this issue. The assessment, which began in November, will be completed in April, 1985.

#### NIH Activities

The NIH is developing a program to promote a greater public understanding of Public Health Service policies designed to assure the humane care and use of laboratory animals. The NIH hopes to involve scientists, legislators, the media and the general public in discussions of issues related to the use of animals in research.

The program will include five initiatives:

- a national symposium on April 11-12, 1984
- regional workshops
- the development of a guidebook for institutional animal committees regarding PHS policies relevant to the use of laboratory animals
- the development of audiovisual materials on a variety of topics surrounding the use of animals in research
- printed material designed to increase public understanding of the essential role of laboratory animals.

Further information about this project can be obtained by calling 301-496-7041.

#### AMA/AAMC/APS Strategy Session

The American Medical Association, the AAMC, and the American Physiological Society have invited several organizations which have been particularly active regarding the animal research issue to participate in an informal discussion of the topic. A meeting will be convened in late April to: develop a consensus on the nature of the issues that surround the use of laboratory animals; share information about current activities; and explore the feasibility of planning collective action. Future strategies for addressing legislation on the Federal and local levels will be discussed. CAS Representatives will receive information about the outcome of this discussion session.



## RESEARCH ROUNDTABLE

The Government-University-Industry Research Roundtable has been established as an independent entity under the aegis of the Council of the National Academy of Sciences. The focus will be on the research university and its principal patrons--government, industry and foundations. The Roundtable will be guided by a group of highly distinguished individuals, the Roundtable Council, who will serve as the Roundtable's conveners, and be managed by a small staff headed by an executive director.

The Roundtable Council will comprise 18 individuals of distinction, maturity, and balance with an understanding of the critical roles of research and research training in achieving national goals; knowledge of the programmatic objectives, operational constraints, and organizational and political realities which characterize the government as it pursues the national interest; a realistic view of the promises and pitfalls of increased industry involvement in university research; a strong sense of commitment to maintaining the health of academic science and engineering and the integrity of the government-university and industry-university relationships; and a broad knowledge of, and experience with, the institutional issues to be addressed by the Roundtable. The Chairman and the other Council members will be appointed by the President of the Academy with the advice and consent of the Academy Council.

The first Chairman of the Council will be Dr. Dale R. Corson. He will serve up to 50 percent time for a period of three years. Dr. Corson is President Emeritus of Cornell University and an active member of the National Academy of Engineering. He served on the National Commission on Research and is intimately familiar with the issues which will constitute the Roundtable's agenda.

The Executive Director will be Dr. Don I. Phillips. Dr. Phillips is a chemist trained at Harvard. From 1973 to 1979 he was involved in science policy affairs in Washington. Since 1979 he has been a special science advisor to Governor James Hunt of North Carolina, Director of the North Carolina Biotechnology Center, and Associate Director of the Roundtable on Science and Public Affairs at Duke University.

The Roundtable will consider the range of issues threatening the continued vitality of the scientific enterprise, together with new ideas, organizational arrangements, and procedures for enhancing that vitality. It will focus its attention on problems and opportunities felt by those individuals intimately involved in government-university-industry partnerships to be most critical to these relationships, and thus, the health of the U.S. scientific enterprise. A variety of approaches are being used to solicit the views of such individuals as the Council formulates an agenda of issues and establishes its priorities. Included will be issues related to: mechanisms used to review and select research proposals, fund individual research projects, and account for the expenditure of public funds; approaches to assuring future research capacity in terms of human and institutional resources, accounting for, controlling, and reimbursing the costs of doing research; scientific integrity; alternatives to federal regulation of research, and implications of the growing interaction between universities and private industry.

## SPECIALTY RESIDENCY (PGY2) MATCH OF MEDICAL STUDENTS

At its September meeting, the AAMC Executive Council adopted two recommendations to address a series of concerns regarding the practice of selecting medical students early in the senior year for the second postgraduate year. These actions were taken in response to concerns raised by the deans regarding the impact of these practices on the educational program of the senior year and coordination with the National Resident Matching Program (NRMP). The first was a recommendation that the NRMP establish an Advisory Panel consisting of a representative of each of the specialties offering an approved residency program (whether or not filling its positions through the NRMP match). The second was a recommendation that the AAMC Executive Committee invite representatives of the specialties of dermatology, neurology, neurosurgery, ophthalmology and otolaryngology to meet with it and a representative of the Group on Student Affairs (GSA) and the Organization of Student Representatives. Both recommendations were designed to pursue the resolution of educational concerns by fostering greater communication between those with varying perspectives.

On December 7, the AAMC Executive Committee held an invitational meeting as had been recommended. Two representatives from each specialty attended and explained in detail their own views of the advantages of an early (senior year) match. The neurologists reported on an indepth study of the preferences of both program directors and current residents on this issue which disclosed the potential desirability of having two matches--one in the senior year--one in the first postgraduate year--to accommodate all of the preferences. The dermatologists reported the decision of the program directors in that specialty to substitute a match in the first postgraduate year for their current senior year match. The neurosurgeons, ophthalmologists and otolaryngologists emphasized the factors that underlay their current match procedures.

The student, GSA and neurology representatives cautioned the other society representatives that the data on candidate satisfaction collected in conjunction with the selection process should be received with a large measure of skepticism. The AAMC staff and leadership, while refraining from exerting any pressure on the selection of the NRMP as the matching mechanism, emphasized both the receptivity and the technical capability of the NRMP to accommodate a much more flexible response to program directors' interests than might have been perceived.

The participants endorsed the AAMC proposal that the NRMP establish an Advisory Panel of program directors on each of the specialties. There was widespread agreement that a productive dialogue had been initiated.

The NRMP board will discuss the Advisory Panel at its meeting on April 24. It has been suggested that the specialties using early senior year matches should meet again to address constructive resolution of the educational concerns.

## STATUS OF STUDENT ASSISTANCE PROGRAMS

Both Title IV of the Education Amendment and Title VII of the Public Health Service Act are due to be renewed for FY 1985. The Education Amendments include a one-year automatic renewal provision. Indications are that Congress will probably not take action this year on its programs of student assistance available to medical students. These include Guaranteed Student Loans (GSL), Parental Loans to Undergraduate Students (PLUS) (also known as Auxillary Loans to Assist Students (ALAS), National Direct Student Loans (NDSL) and College Work-Study (CW-S). A second year medical student at George Washington University recently testified before the House Subcommittee on Postsecondary Education regarding Chairman Paul Simon's (D-IL) Higher Education Act Reauthorization Proposal, (H. R. 5240). The major themes of this testimony, consistent with the position of the AAMC, included the need for medical students to remain eligible for Title IV student assistance programs; the centrality of the Guaranteed Student Loan Program to medical student financing, and the need for medical school graduates to have loan consolidation and flexible refinancing options. The importance of manageable debt burdens, income contingent loan repayment plans and the ability of medical students to utilize the College Work Study Program were also mentioned.

Charles Terrell, assistant dean for student affairs at Boston University School of Medicine, testified for the AAMC before the Senate Labor and Human Resources Committee concerning the renewal of Health Manpower authorities which include Health Education Assistance Loans (HEAL), Health Professions Student Loans (HPSL), Exceptional Financial Need (EFN) Scholarships and National Health Service Corps (NHSC) Scholarships. Since no legislation has been introduced to renew the expiring authorities in Title VII, testimony focused on the existing programs which the Association strongly supports.

Other current student assistance issues include the fact that 37 schools remain on probation in the HPSL program and have until December 31, 1984 to improve their HPSL delinquency rates sufficiently to be returned to good standing. Those that fail to do so will be suspended from the program and therefore unable to make loans from either new or revolving HPSL funds. The Administration has proposed that \$5 million be removed from the EFN Scholarship Programs funding, which would effectively close it out, and be added to the HPSL program with \$2.5 million to go to medical schools with underrepresented minority enrollments of 50 percent or more and \$2.5 million to go to schools with underrepresented minority enrollments of 10 to 49 percent. Of course, any schools suspended from the HPSL program next December would be ineligible to use these additional HPSL funds.

The Armed Forces Health Professions Scholarship Program is not scheduled for renewal this year. However, as a result of improved recruitment and retention of physicians in the military, the number of recipients will be reduced from 5,000 to 3,600 by 1986.

## SMALL BUSINESS COMPETITION FOR FEDERAL CONTRACTS

Legislation to create another small business set-aside--this time specifically for contracts--has been reported from the House Small Business Committee. The bill (H.R. 2133) was introduced by Representative Parren J. Mitchell (D- MD) and is scheduled for floor action on May 15.

Two provisions in this multifaceted bill are of concern to the academic community. We understand that the first, discussed below, will be satisfactorily addressed on the floor. The second requires further attention.

The Under \$2 Million Presumption - Under this section of the bill, all contracts under \$2 million would automatically be set-aside for a small business. The section mandates that contracting officers must presume that if a contract is under \$2 million, the requirements for a small business set-aside, or for an award to a disadvantaged small firm under the Small Business Administration 8a program, have been met. The presumption could only be overturned if the buying activity offers "substantial" reason to believe that the presumption is not warranted.

The AAMC understands that a committee amendment will be offered on the floor to exempt "the procurement of research and development and other professional, scientific, technical and management services" from this section.

The Rule of Two - Under the "rule of two", all contracts must be set-aside for small businesses when the procurement officer has a reasonable expectation that:

- two or more small businesses will bid;
- the bids will be at reasonable prices, and
- the goods and services will be delivered in a timely manner.

Any disagreement on such a set-aside determination would be resolved by the agency's Director of Small and Disadvantaged Business Utilization.

A similar set-aside is provided for in the Federal Acquisition Regulations (FAR) which went into effect on April 1. The FAR is a massive rewrite and systemization of government procurement regulations. Section 19.502-2 establishes a "rule of two" set-aside for small businesses. However, unlike H.R. 2133, the regulation contains the following language. "In making R&D small business set-asides, there must also be a reasonable expectation of obtaining from small businesses the best scientific and technological sources consistent with the demands of the proposed acquisition for the best mix of cost, performances, and schedules."

Staff to the Small Business Committee has indicated Committee willingness to include the full language of the FAR in the bill. However, Chairman Mitchell is adamantly opposed to an outright research exemption.

The bill would clearly force procurement officers to award contracts to small businesses whenever a minimum of two could qualify for competition. This is hardly open or fair competition. It ignores the basic tenant of good procurement policy which is to look for the best product at the best price. Finally, it would disallow much of the productive contracting that has occurred between the federal government and academic research institutions.

Stiff opposition to the bill has arisen in many quarters. Representative Jack Brooks (D-Tx), Chairman of the Government Operations Committee has written Small Business Committee Chairman Mitchell: "It is inherently unfair to turn over the Federal market place to any single economic group to the exclusion of all others---As a long time supporter of the small business community...I deeply regret that I must oppose this legislation as it now stands. However, I am left with no other choice." Representative John D. Dingell (D-Mi), Chairman of the Energy and Commerce Committee, expressing concern about the set-aside sections of the bill wrote: "I urge that House consideration of this bill be deferred until we have an opportunity to work out our concerns about these and possibly other provisions in the bill." Representative Don Fuqua (D-Fl), Chairman of the Science and Technology Committee, has written: "Under the 'Rule of Two'...as long as two small businesses meeting the stated criteria were found, scientific and technical expertise and quality would be virtually irrelevant. This approach, in my view, serve neither the interests of government, nor small business...Consequently, I feel it essential that the section be amended to exempt from its application the procurement of research and development and other scientific and technical services." Representative Melvin Price (D-Il), Chairman of the House Armed Services Committee wrote Chairman Mitchell expressing concerns in several areas beyond those regarding set-asides outlined here. Further, AAMC staff understands that other committee chairmen are also deeply disturbed about the bill.

The opposing Chairmen are apparently planning to formulate a substitute bill that would address all of these objections. There is a reasonable possibility that the substitute will not even include a "rule of two" set aside. Should that not be the case, however, another way of addressing the problem will have to be worked out.

## STATUS OF RESEARCH FACILITIES AND INSTRUMENTATION

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

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

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

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

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

by the National Science Foundation, Department of Agriculture, Department of Defense, Department of Energy, and the National Aeronautics and Space Administration and carried out by the Association of American Universities, National Association of State Universities and Land-Grant Colleges and the Commission on Government Relations, this is a 16-month project, with the objective of "increasing awareness among research universities of opportunities for better planning and management of research equipment at all levels." The project is planned in three phases. In phase I, six analyses will be conducted to:

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

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

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

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

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

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

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

#### (4) Legislative Incentives

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

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

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



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

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

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

"Estimate:

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

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

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

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

## INDIRECT COSTS ON NIH RESEARCH GRANTS

The Government and the Congress have been concerned with the level of funding required to reimburse indirect costs, the complexity of accounting procedures used by educational institutions, and the need to maintain appropriate accountability. Educational institutions have emphasized the need for increased recovery of their costs expended to conduct federally sponsored research activities.

In the last few years, attempts have been made to reduce the level of reimbursement for indirect costs associated with NIH research grants. For the short term, it is anticipated that full reimbursement of indirect costs will be possible in FY 1985. For the longer term, a number of efforts have been or will be undertaken to explore this issue in-depth.

- GAO Report: Assuring Reasonableness of Rising Indirect Costs on NIH Research Grants--A Difficult Problem

The General Accounting Office has just released a report on the problem of increasing indirect costs. Indirect cost reimbursement has risen from \$166 million in 1972 to \$690 million in 1982. These costs represent an increasing proportion of the federal research dollar-- 21 to 30 percent during the same period. GAO's recommendations are based largely on the fact that departmental administration expenses represent the largest and most controversial of the indirect costs reimbursed by NIH.

The government-wide process used to establish indirect cost reimbursement rates for educational institutions is set forth in OMB Circular A-21. GAO found that the process followed by HHS in negotiating indirect cost reimbursement rates does not assure that those rates are reasonable, particularly with respect to departmental administration expenses which are difficult to identify and verify.

*The GAO report recommends that the Director, OMB, revise Circular A-21 to establish a fixed allowance for large institutions' departmental administration expenses to replace the cost reimbursement method now used. Such an allowance would be computed in a manner similar to that permitted by Circular A-21 for small institutions and could vary, if necessary, on an institution-by-institution basis, depending on their individual circumstances. A fixed allowance for departmental administration expenses should not require reliance on an institution's personnel activity reporting systems and should represent a reasonable amount needed for effective research administration at each institution.*

The GAO report points out that this recommendation is consistent with a May 1983 National Academy of Sciences report which stressed that a single uniform indirect cost rate applicable to all universities for all indirect costs would be unsound and inequitable. The establishment of a fixed departmental administration allowance--possibly unique to each institution--could complement the Academy's call for alternate and more simplified methods of allocating indirect costs.

- Faculty Effort Reporting for Indirect Cost Accounting

On October 29, 1983 the National Academy of Sciences sponsored a workshop on the effort reporting requirements of OMB Circular A-21; that is, effort reporting necessary to document 100% of each faculty member's effort to permit calculation of the departmental administration component of indirect cost recovery. The meeting was attended by senior faculty and research administrators from a number of research intensive universities. Some discussion was devoted to the difficulties and inherent inconsistencies in attempts to separate categories of faculty effort between research and teaching and patient care and teaching, especially with advanced trainees, as well as the philosophic objections of some to the concept of effort reporting by faculty.

Attention focussed heavily on the agreements negotiated by Yale and Stanford universities which have permitted them to discontinue faculty indirect cost effort reporting in return for establishing a fixed, historically derived percent for costs in the departmental administration category (19.25% Yale, 19.8% Stanford). These agreements, permitted under the newest revision of A-21, were praised as a successful method for eliminating 100% faculty effort reporting which should be investigated by other institutions. It was noted that medical school faculty effort reports for patient care reimbursement and state reporting requirements at some public universities would not be alleviated by such agreements.

- OSTP to Study Indirect Cost Policies

Following requests by NIH and eventually by HHS, the President's Office of Science and Technology Policy has agreed to undertake a government-wide review of indirect cost reimbursement policies for federally funded research. This review is expected to focus on principles of reimbursement and recent recommendations such as the Grace Commission proposals rather than on specific scrutiny of OMB Circular A-21.

## PROPOSED CHANGES IN MEDICARE REIMBURSEMENT POLICIES

Congress has yet to complete work on the budget reconciliation, the legislative vehicle that would implement the FY 1984 Budget Resolution. As part of this effort, the Senate Finance Committee has completed its mark up of portions of the Omnibus Reconciliation Act of 1983 (S. 2062). The recommendations of the Committee will ultimately become part of a \$150 billion budget reduction package incorporated into S. 2062.

On the House side, the Ways and Means Committee has completed most of its work on the "Tax Reform Act of 1984" (H.R. 4170) and now separate spending reductions including Medicare and Medicaid proposals. Its recommendations will be incorporated into a \$183 billion budget reduction package. Proposals common to both bills are shown below:

- A Freeze on Payments for Physicians' Services:

Senate: 12-24 months  
House: 12 months  
(see Medicare Assignment)

- Medicare Assignment

Senate: If physicians accept assignment of claims for all Medicare patients, the freeze on physician fees would be limited to 12 months; otherwise the freeze would apply for 24 months.

House: Requirement for physicians to accept assignment of claims for Medicare for all services provided to hospital inpatients. This provision would remain in effect until six months after the Congress receives the D/HHS Secretary's report and recommendations regarding the feasibility of including payments for inpatient physician services in the DRG prospective payment system. The report is due on July 1, 1985.

- Freeze on DRG Payment

Neither the House nor Senate have indicated willingness to actively pursue legislation which would freeze the way in which Medicare prospective rates are calculated. This was recommended by the Subcommittee on Health of the House Ways and Means Committee and supported by the AAMC. Such legislation would have slowed the move toward national DRG rates by retaining for one more year the current split in which 75% of the payment each hospital receives is based on its own costs and 25% is based on regional DRG rates. Thus, effective October 1, 1984 Medicare payments to hospitals will be based 50% on the hospital's own costs, 37.5% on regional DRG rates and 12.5% on the national DRG rates.

- Eliminating 1% Increase for New Technology

Current estimates of future Medicare expenditures are based on the premise that the D/HHS secretary will allow an annual rate of increase equal to the rate of inflation plus 1% for technology changes. Using a complicated set of adjustments, current proposals would in effect, eliminate the 1% annual increase for new technology. (Note--this proposal is currently under review and may be subject to change.)

- Outpatient Clinical Laboratory Services

A maximum payment schedule for outpatient clinical laboratory services, including hospital outpatients, would be established at approximately 60% of the prevailing fee.

## NONDISCRIMINATION ON THE BASIS OF HANDICAP: "BABY DOE"

Regulatory Activity: Regulations developed by the Department of Health and Human Services (D/HHS) to assure that handicapped infants receive "appropriate" medical treatment became effective on February 7. The original proposal required that notices stating the prohibition on discrimination be posted in prominent locations and offered a toll free number for anonymous reporting of potential violations. A number of concerned organizations actively opposed the proposal. A revised rule required that notices be posted at nurses' stations, a solution which most felt did not begin to significantly address the serious problems associated with these rules. Efforts to delay implementation of the final regulations were unsuccessful. A summary of the final rules follows:

- Requires that notices stating the prohibition on discrimination be posted but permits such posting in areas accessible only to employees
- Encourages establishment of Infant Care Review Committees (ICRCs) to review cases in which a decision to forego life sustaining treatment is under consideration (provides guidelines as to composition)
- Strengthens the role of state child protection agencies and the Office of Civil Rights to assure that there is no "unlawful medical neglect" in treating handicapped infants
- Maintains hotline for anonymous reporting of potential violations although suggests (but does not require) that individuals contact either the ICRC if one exists or the state child protection agency before contacting D/HHS.

The AAMC has joined five other medical associations and several physicians in filing suit in Federal District Court for Southeastern New York asking for a preliminary injunction against the final "Baby Doe" regulations. The second U.S. circuit court issued a decision on February 28 in which it dismissed the request of D/HHS to obtain the records of the well publicized "Baby Jane Doe" case by determining that Section 504 of the Rehabilitation Act, under which these regulations had been promulgated, was never intended to apply to such medical decisions. The decision stopped just short of actually invalidating the regulations. The suit is intended to require the lower court to strike down the regulations based on the circuit court's decision. The objective is to have the decision applied nationally.

Legislative Activity: The House has passed an amendment to the Child Abuse and Prevention and Treatment Act (H.R. 1904). The Act requires state child protection agencies, hospitals and health care providers to follow guidelines set by D/HHS intended to ensure that "...nutrition, medically indicated treatment, general care and appropriate social services are provided to infants at risk with life-threatening congenital impairments." In addition, procedures must be established to enable any interested person to report suspected violations to the "appropriate" authorities. The bill redefines child abuse to include withholding of medical treatment and nutrition. Such legislation would strengthen the authority for actual implementation of regulations.

On the Senate side, Senate Robert Packwood (R-OR) has placed a hold on the Child Abuse Act (S. 1003) because of an amendment similar to the House-passed language currently included in the bill. S. 1003 would require an HHS advisory committee to conduct a comprehensive study of the decision-making procedures used in health care facilities in managing the treatment of seriously ill newborns and to make recommendations regarding the procedural mechanisms that should be followed by hospitals. If the bill goes to the floor, Senator Nancy Kassebaum (R-KS) is expected to offer an amendment that will delete all language defining treatment decisions as child abuse and call for voluntary establishment of hospital infant care review committees.

## ORGAN TRANSPLANT LEGISLATION

House: The Subcommittee on Health of the House Ways and Means Committee has reported the National Organ Transplant Act (H.R. 4080), sponsored by Representatives Albert Gore (D-TN) and Henry Waxman (D-CA). The primary purpose of the Act is to authorize financial assistance for the establishment and operation of a transplantation network to aid organ procurement organizations in obtaining and distributing organs. H.R. 4080 includes Medicare/Medicaid amendments which have caused some concern. The language has been interpreted by some to mean that the Secretary of the Department of Health and Human Services would have unlimited authority to determine the patients and physicians who would have access to any type of technology and procedures and the sites at which they may be performed as criteria for payment. However, it has been learned that the intent of the language is to allow the Secretary to authorize payments for new technologies/procedures as they move from the experimental to the tried and proven stage. The bill has already been passed by the House Energy and Commerce Committee.

The AAMC wrote to the Subcommittee and full Committee in general support of the concept but has recommended that, for the time being, it be applied only to new procedures and technologies related to organ transplant. Selected CAS societies were informed with respect to this legislative initiative. The recommendation to narrow the scope of the bill was not incorporated into the Subcommittee's version of H.R. 4080. The full Ways and Means Committee is expected to consider the bill in the near future.

Senate: The Senate Labor and Human Resources Committee has passed S. 2048 introduced by Senator Orrin Hatch (R-UT). This bill would authorize seed money for creation of a national organ procurement network within the private sector. It does not include comparable Medicare/Medicaid provisions. Both the Senate and House bills would establish a task force to examine the social, legal and ethical issues associated with transplantation.



## LOW-LEVEL NUCLEAR WASTE DISPOSAL

At present, all of the nation's commercial low-level nuclear waste is disposed of at three shallow land burial sites in the states of Nevada, South Carolina, and Washington. These sites will not be adequate to continue to handle the expanding volumes of low-level waste. Moreover, the governors of the three states have made it clear that they will no longer bear the entire burden as the nation's only low-level nuclear dumping grounds. To help resolve this dilemma, the Low-Level Radioactive Waste Policy Act (P.L. 96-573) was enacted in December 1980.

This law gave the states the responsibility for disposing of low-level nuclear waste and encouraged them to form interstate compacts and construct regional disposal facilities. The law established January 1, 1986, as the date by which these compacts must be Congressionally approved and their disposal sites operational. As of that date, as well, an approved compact could exclude outside (nonmember) states from using its disposal facilities. Presently, six regions are in various stages of compact formation: Central, Midwest, Northeast, Northwest, Rocky Mountain, and Southeast. With few exceptions, every state is associated with a regional compact. California and Texas plan to develop sites for their own exclusive use. West Virginia has requested membership in the Midwest Compact.

As mandated by P.L. 96-573, all regional compacts must receive prior Congressional consent and the President's signature before enactment. It is through this approval process that the Congress will exercise its oversight responsibility for implementation of the law. Thus, the process of Congressional approval of proposed regional compacts will resemble the normal legislative process. Congressional committees of primary jurisdiction include the Senate Judiciary and Energy Committees and the House Committees on Interior and Insular Affairs and Energy and Commerce. To date, four regional compacts have been introduced in both the House and Senate:

- Northwest Regional Compact (S. 247 and H.R. 1012)
- Central Regional Compact (S. 1581 and H.R. 3002)
- Southeast Regional Compact (S. 1749 and H.R. 3777)
- Rocky Mountain Regional Compact (S. 1991 and H.R. 4388)

Unless interstate agreements on these compacts are reached soon in some parts of the nation and approved by Congress, generators of low-level nuclear waste in those regions, such as hospitals and universities, may be without a place to dispose of this waste. In many instances, these institutions now store waste containing short-lived radionuclides in safety drums until its radioactive life has expired. However, the radioactive material used by medical and research facilities is manufactured by means of processes that often produce longer-lived, low-level nuclear waste that cannot be safely or efficiently stored for the period of its radioactivity. Thus, the failure to implement all proposed regional compacts in a timely manner could lead to denial of access to dumping sites not only for hospitals and research facilities, but also for the manufacturers of their nuclear medicine supplies and materials. Should this scenario be permitted to unfold, it could force the cessation or severe curtailment of nuclear medicine diagnostic and therapeutic techniques and radioactive biomedical and pharmaceutical research.

Potentially undesirable conditions to be watched for include: unwarranted exclusionary or discriminatory provisions; duplicative inspection programs; burdensome indemnity and certification requirements; inequitable shared liability protections; and nonuniform and unnecessarily strenuous definitions and standards. A major concern is the January 1, 1986 deadline for creation of these new disposal sites.

Most expert observers believe that no more than two of the compacts (in the Northwest and Southeast, where dump sites are already in operation in Washington and South Carolina, respectively) will be ready by that date. Therefore, an extension of access to these existing sites by other nonmembers of these two compacts beyond the 1986 date, conditioned on the outside region or state's demonstration of "due diligence" in moving toward implementation of its own compact/dump site, may be in order. Concerned individuals are encouraged to:

1. Become more familiar with the provisions and requirements of the Low-Level Radioactive Waste Policy Act (PL 96-573).
2. If your state has ratified a compact, contact the appropriate university and/or state officials to learn what the provisions and requirements of that compact are and how they may affect the academic medical center. Look for potentially troublesome conditions such as those discussed in the preceding section. Convey your concerns both individually and through the university to the appropriate state officials and legislators.
3. If your state has not yet ratified its compact, request that the appropriate officials at your university actively encourage state officials and legislators to pursue development and ratification of reasonable compact consent legislation. Convey concerns regarding this legislation to the appropriate state officials and legislators.
4. If other states in your region have not yet ratified the compact legislation, urge university officials to work in conjunction with state officials to actively encourage ratification in these remaining eligible states.
5. If your region's compact legislation has already been submitted for federal oversight approval, urge appropriate Congressional Committees to expedite the process of review and approval. Encourage development of inter-regional agreements which would avert the potential January 1986 access crisis.

## HAZARDOUS WASTE LEGISLATION

House: The House has passed legislation amending the Resources Conservation and Recovery Act (RCRA, H.R. 2867). The bill lowers the current threshold for small quantity generators from 1000 kg/month to 100 kg/month of hazardous chemical waste (non-infectious, non-radioactive waste). How generators are defined will determine whether or not academic medical centers will be subject to the provisions of the legislation.

The House bill requires EPA to issue regulations within 18 months of enactment for generators between 100 and 1000 kg of hazardous waste per month. Generators of 25 or more kg/month will be required to notify transporters and waste sites of the type, quantity, and origination of the waste. If EPA fails to issue the required rules within 30 months of enactment, newly regulated generators will have to comply with a limited set of requirements.

Labpacks are prohibited by the House bill within 12 months of its enactment unless EPA certifies that there is no alternative waste management mechanism available, and that their use will not cause damage to human health or the environment. A final determination will be required from EPA no later than 54 months after passage of the bill.

Senate: The authorizing committee in the Senate has reported S. 757 which also sets the small quantity generator exemption at 100 kg/month for regulatory requirements. S. 757 would impose the full array of RCRA regulations on small generators if EPA does not issue separate regulations for these generators in a timely fashion. The Senate bill is stricter than the House version in its waste packaging requirements for the newly regulated generators. The issue of labpacks is not addressed, however, report language accompanying the bill encourages the use of labpacks. The bill has not yet been considered on the floor.

SOCIAL SECURITY ADVISORY COUNCIL RECOMMENDATION REGARDING  
MEDICAL EDUCATION EXPENSES

Background: The Social Security Advisory Council, convened for an 18 month period, released its final report in January of this year. Included were recommendations regarding the use of the Medicare Hospital Insurance trust fund for the training of physicians, nurses, and other health care professionals. Medicare's share is based on the proportion of total charges accounted for by Medicare patients. In this manner, Medicare funds help support the advanced clinical training of medical school graduates.

In 1980, the Hospital Insurance trust fund spent an estimated \$1.4 billion for the direct and indirect cost of medical education programs. These expenditures are expected to be \$1.8 billion in 1983.

The Advisory Council estimates that if Medicare funding for these programs is withdrawn in 1987, the total program savings through 1995 could eliminate up to 20 percent of the projected deficit. The exact amount cannot be predicted because residents provide substantial medical service during their training.

Recommendation:

*"In view of the financial crisis facing the Medicare program and the expanding supply of physicians and other health care professionals, the Advisory Council on Social Security believes that there is a serious question concerning the use of the Medicare Hospital Insurance trust fund for the training of physicians, nurses, and other health care professionals. The Council recognizes that the Medicare program has had a significant impact upon the supply of health professionals by subsidizing the expenses of training and medical education for these groups. However, the Council thinks that the involvement of the Medicare program in underwriting these costs is inappropriate since the program is designed to pay for medical services for the elderly, rather than to underwrite the costs of training and medical education.*

*The Council recognizes that the extent of public support for medical education and training of health professionals is a complex and difficult matter to determine and implement. The abrupt discontinuance of the use of the Medicare Hospital Insurance trust fund for medical education without analysis of the impact upon training institutions and a concomitant search for alternative public funding sources would be a disservice to the training and medical education institutions in the country and to the training of prospective health care professionals. The Council believes that a study on the restructuring of medical education financing should be undertaken immediately in order to recommend another source for training support that is now being provided under the Medicare program. The Council does not intend to suggest that governmental funding for medical education is inappropriate. This study should be completed within three years under the direction of the D/HHS."*

The Council was established as an advisory body to the Health Care Financing Administration. The actual strength of this recommendation is unclear at this time.



**association of american  
medical colleges**

**AGENDA  
FOR THE  
COUNCIL OF ACADEMIC  
SOCIETIES**

**SPRING MEETING**

**APRIL 10-11, 1984**

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

*"What are the issues and challenges  
facing medical school faculty in the next five years?"*

## 1984 Spring Meeting

### Council of Academic Societies

The rapidly changing environment of our medical schools today gives rise to new challenges to the academic enterprise. Some of these challenges present creative opportunities and others require that we identify clearly and seek to preserve the essence of the academic environment in the face of countervailing priorities. To adapt to challenges and thrive in the present milieu academic medical centers are taking stock of their goals, priorities and organizational structure and Councils of the AAMC have also decided that such an effort would be beneficial.

Each Council is attempting to define the issues and challenges most central to its concerns, from its perspective as a representative of teaching hospitals, medical school administration or faculty. While many issues are of mutual concern, it is equally important to identify issues unique to one constituency and major differences in emphasis or priority.

The first day of the CAS Spring Meeting will be devoted to identifying the issues which you believe will be of most concern to faculty in the coming years and which may benefit from concerted attention at a national level.

On the second day, the meetings will focus on strategies for meeting these challenges; and especially on the roles which the individual academic societies, and societies collectively through CAS, may play in such efforts. Many societies may be able to provide examples of successful efforts to assist their members in carrying out their education, research or patient care missions. Appropriate goals and strategies for the Council as a whole will be discussed, as well as the function of the Council and its academic societies as the forum for faculty participation in the AAMC. As background for this discussion, an historic perspective on the founding and past function of the CAS is attached for your review.

Challenges identified, organizational issues raised and strategies adopted at this CAS Spring Meeting will form the basis of a planning paper for future CAS activities and for communication to the other Councils for AAMC-wide strategic planning.

MEETING SCHEDULE

Tuesday, April 10

10:00 am	PLENARY SESSION	THOROUGHbred ROOM
	Keynote Address	
	<i>Kern Wildenthal, M.D., Ph.D. Dean, University of Texas Southwestern Medical School at Dallas</i>	
	What are the Challenges in Medical Education?	
	<i>Victor R. Neufeld, M.D., F.R.C.P. (C) Chairman, the M.D. Program McMaster University</i>	
	What are the Challenges in Research?	
	<i>Ronald W. Estabrook, Ph.D. Professor of Biochemistry University of Texas Southwestern Medical School at Dallas</i>	
	What are the Challenges in Patient Care?	
	<i>Kenneth I. Shine, M.D. Chairman, Department of Medicine UCLA School of Medicine</i>	
	What are the Challenges for Medical School/Medical Center Governance?	
	<i>Edward J. Stemmler, M.D. Dean, University of Pennsylvania School of Medicine</i>	
12:30 pm	LUNCHEON	GEORGETOWN WEST ROOM
2:00 pm	WORKSHOPS	(ROOMS TO BE ASSIGNED)
	<i>Small groups of CAS Representatives will meet to attempt to identify the major challenges that will confront faculty in the areas of education, research, patient care, and institutional governance.</i>	
4:00 pm	CONSENSUS SESSION	HEMISPHERE ROOM
	<i>Representatives will reconvene to review conclusions reached during the workshops and for an overall discussion of the challenges identified.</i>	
5:00 pm	RECEPTION	CABINET ROOM

MEETING SCHEDULE

Wednesday, April 11

8:30 am

DISCUSSION SESSION

GEORGETOWN WEST ROOM

*Following a day devoted to identifying the major challenges that will confront medical school faculty in the next five years, this morning session will focus on how these areas of concern can be addressed in an effective and timely manner.*

The Role of Individual Societies:  
Efforts to Meet the Challenges

Education

*Joseph E. Johnson, III, M.D.  
Chairman, Department of Medicine  
Bowman Gray School of Medicine  
(Association of Professors of Medicine)*

Research

*David H. Cohen, Ph.D.  
Chairman, Department of Neurobiology  
SUNY at Stony Brook  
(Society for Neuroscience)*

Patient Care

*Frank G. Moody, M.D.  
Chairman, Department of Medicine  
University of Texas at Houston  
(Society of Surgical Chairmen)*

The Role of the CAS: Assisting Societies  
to Meet the Challenges

*Appropriate goals and strategies for the Council as a whole will be discussed, as well as the function of the Council and its academic societies as the forum for faculty participation in the AAMC.*

11:30 am

ADJOURNMENT



## HISTORY OF THE COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies held its first meeting 17 years ago. In 1967 direct federal support for the education of medical students was just beginning to effect an increase in class size and an expansion in the number of medical schools. The effect of Medicare and Medicaid was beginning to modify the clinical environment for the education of both residents and students. Support for biomedical research, which had been steadily increasing, was plateauing. These national developments tended to set the agenda for the Council of Academic Societies during its first 15 years.

Now, the issues are changing. Direct support for expansion of the nation's medical education capacity was phased out in 1980. The medical care system is in the midst of a major evolutionary change, which is, in large measure, stimulated by concerns about health care costs in both the public and private sectors. Rather than a shortage of physicians, there are now concerns about an excess. Federal support for biomedical research continues, but maintaining an appropriate level of support requires major effort, and attempts to reorganize and politicize the National Institutes of Health and ADAMHA are a continuing threat. The need for even greater involvement by the academic medical community in public affairs seems apparent.

There also are issues and problems within our institutions that concern faculties. The opportunities for young faculty members to embark on a career are constrained both by diminishing institutional resources and by high competition for external research support. There is a growing reliance on income derived from the medical services provided by faculties for institutional support. The educational program for medical students has become more and more intense as biomedical knowledge and technology have expanded. The number of graduate medical education positions is approaching unity with the number of

graduates from U.S. medical schools. Yet, in excess of 2,000 U.S. citizen graduates of foreign medical schools annually are trying to enter accredited residencies. Fewer than 50 percent are successful.

Changing issues and changing times require assessment of how the Council of Academic Societies and the Association of American Medical Colleges should be positioned to continue their purpose, which is to advance academic medicine and medical education. The following summary history of the CAS provides background to facilitate discussions about the future.

### Establishment and Early History

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

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

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

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

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

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

#### ASSOCIATION OF AMERICAN MEDICAL COLLEGES

#### ORGANIZATIONAL MEETING OF THE COUNCIL OF ACADEMIC SOCIETIES

January 10, 1967

Ramdada Inn-O'Hare, Chicago, Illinois

**PRESENT:** William N. Hubbard, Jr., Chairman  
Robert C. Berson  
Cheves McC. Smythe

George Aagaard  
Eben Alexander, Jr.  
John A. Campbell  
Philip P. Cohen  
Kenneth R. Crispell  
James B. Snow, Jr.  
Donald Duncan  
Harry A. Feldman  
Patrick J. Fitzgerald  
Robert E. Forster  
A. Donald Merritt

Thomas D. Kinney  
A. Edward Maumenee  
Jonathan Rhoads  
Morris Frank Shaffer  
Robert Slater  
Daniel C. Tosteson  
Raymond F. Waggoner  
James V. Warren  
Ralph Wedgwood  
Robert H. Williams  
Russell T. Woodburne

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Growth and Development

In 1966 John Cooper became President and completed the move of the Association to Washington, D.C. This transition enhanced the emphasis on AAMC's becoming a major voice in national policies affecting medical education, biomedical research, and medical care. For the Council of Academic Societies, a strong and persistent focus on biomedical research policy and funding evolved, and in the early 1970s the Division of Biomedical Research and Faculty Development was established with Michael Ball, immediate past President of the AFCR, as its first Director. That office has been the central focus of the CAS.

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

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

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

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



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

#### The AAMC - A Consensus Organization with a Centralized Governance

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

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

However, this experience has not been extended to the representatives of CAS member societies to a significant degree. The letter on page 15 from the representatives of the Association of University Anesthetists expresses feelings that are probably shared by many CAS representatives. In the main, CAS representatives and their member societies are recipients of information from the AAMC rather than initiators of input to the AAMC.

### A Diverse Constituency

Members of the Council of Deans and the Council of Teaching Hospitals hold their membership in those Councils by virtue of their professional positions. For both deans and teaching hospital executives, these are the principal national organizations that are concerned with their day to day interests and responsibilities. The CAS constituency is composed of diverse academic societies (see page 17) that appoint representatives to participate in the business of the Council, but the professional interests and responsibilities of these representatives are only tangential to the activities of the CAS and AAMC. Further, representatives rarely can speak for their societies because the timing of CAS meetings and the timing of member society meetings do not permit most societies to consider items on the CAS agenda in advance of a CAS meeting.

### Questions to Consider

1. The founders of the Council of Academic Societies conceived of its mission as principally educational. Has the Council concentrated sufficiently on medical education?
2. Member societies of CAS have uniformly supported enhanced appropriations for NIH and ADAMHA. Should this effort be maintained at present levels, increased, or decreased?
3. The diverse interests of CAS member societies have on occasion led to conflict on policy. Have issues such as new NIH institutes been excessively divisive? Have they weakened the Council?
4. Is there sufficient and clear communication between AAMC staff and the member societies?

5. Is there useful communication among societies resulting from their membership in CAS?
6. Has the CAS generated a closer working relationship between faculties, deans, and hospital directors?
7. How might the modes of operation of the Council be modified to enhance its effectiveness as one of the three Councils of the Association of American Medical Colleges?

1983-84 Membership List for the Council of Academic Societies

BASIC SCIENCES

ANATOMY

American Association of Anatomists  
Association of Anatomy Chairmen

BEHAVIORAL SCIENCE

Association for the Behavioral Sciences and Medical Education

BIOCHEMISTRY

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

CELL BIOLOGY

American Society for Cell Biology

GENETICS

American Society of Human Genetics

MICROBIOLOGY

Association of Medical School Microbiology Chairmen

NEUROSCIENCE

Society for Neuroscience

PHARMACOLOGY

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

PHYSIOLOGY

American Physiological Society  
Association of Chairmen of Departments of Physiology

CLINICAL SCIENCES

ALLERGY

American Academy of Allergy

ANESTHESIOLOGY

Association of University Anesthetists  
Society of Academic Anesthesia Chairmen

CLINICAL RESEARCH

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

DERMATOLOGY

Association of Professors of Dermatology, Inc.

EMERGENCY MEDICINE AND CRITICAL CARE

Society of Critical Care Medicine  
Society of Teachers of Emergency Medicine

ENDOCRINOLOGY

Endocrine Society

FAMILY MEDICINE

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

GENERAL SURGERY

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

INTERNAL MEDICINE

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

NEUROLOGY

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

NEUROSURGERY

American Association of Neurological Surgeons

OBSTETRICS AND GYNECOLOGY

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

OPHTHALMOLOGY

American Academy of Ophthalmology  
Association of University Professors of Ophthalmology

ORTHOPAEDICS

American Academy of Orthopaedic Surgeons  
Association of Orthopaedic Chairmen

OTOLARYNGOLOGY

Association of Academic Departments of Otolaryngology  
Society of University Otolaryngologists

PEDIATRICS

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

PHYSICAL MEDICINE AND REHABILITATION

American Academy of Physical Medicine and Rehabilitation  
Association of Academic Physiatrists

PLASTIC SURGERY

American Association of Plastic Surgeons  
Plastic Surgery Educational Foundation

PSYCHIATRY

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

RADIOLOGY

Association of University Radiologists  
Society of Chairmen of Academic Radiology Departments

THORACIC SURGERY

American Association for Thoracic Surgery  
Thoracic Surgery Directors Association

UROLOGY

Society of University Urologists

HEALTH AND HUMAN VALUES

Society for Health and Human Values

PATHOLOGY AND CLINICAL LABORATORIES

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

PREVENTIVE MEDICINE

Association of Teachers of Preventive Medicine

THE CHALLENGES IN INSTITUTIONAL GOVERNANCE

Moderators: David H. Cohen, Ph.D. Room: Jackson  
Virginia V. Weldon, M.D.

CAS Staff: Elizabeth M. Short, M.D.

Participants:

S. Craighead Alexander, M.D.	Society of Academic Anesthesia Chairmen
Philip C. Anderson, M.D.	Association of Professors of Dermatology, Inc.
David Baime	Association of American Medical Colleges
Joe Dan Coulter, Ph.D.	Society for Neuroscience
Paul J. Friedman, M.D.	Association of University Radiologists
Paul Jolly	Association of American Medical Colleges
Robert I. Kohut, M.D.	Association of Academic Departments of Otolaryngology
Richard I. Shader, M.D.	American Association of Chairmen of Departments of Psychiatry
Samuel Shelburne, M.D.	Child Neurology
Kat Turner	Association of American Medical Colleges
Peyton E. Weary, M.D.	Association of Professors of Dermatology

CHALLENGES IN PATIENT CARE

Moderators: Joseph E. Johnson, III, M.D. Room: Independence  
Frank G. Moody, M.D.

CAS Staff Lynn Morrison

Participants:

Warren Y. Adkins, M.D.	Association of Academic Departments of Otolaryngology
William Donovan, M.D.	American Academy of Ophthalmology
Donald O. Davis, M.D.	Association of University Radiologists
Harry C. Miller, Jr., M.D.	Society of University Urologists
Xenia Tonesk, Ph.D.	Association of American Medical Colleges
Marvin Turck, M.D.	American College of Physicians
Peter M. Zeman, M.D.	American Association of Directors of Psychiatric Residency Training



CHALLENGES IN MEDICAL <sup>EDUCATION</sup> ~~RESEARCH~~

Moderators: Frank G. Wilson, M.D. Room: Kalorama  
Harold S. Ginsberg, M.D.

CAS Staff: August C. Swanson, M.D.

Participants:

Lewis Aronow, M.D.	Amer. Soc. for Pharmacology & Experimental Therapeutics
Arthur K. Asbury, M.D.	American Neurological Association
Lewis B. Barnett, Jr., M.D.	Society of Teachers of Family Medicine
Paul C. Bianchi, M.D.	Association for Medical School Pharmacology
Thornton E. Bryan, M.D.	Association of Departments of Family Medicine
Lewis M. Flint, M.D.	Society of University Surgeons
Jack Ginsburg, M.D.	American College of Physicians
Solomon G. Hershey, M.D.	Society of Critical Care Medicine
Douglas R. Knab, M.D.	Association of Professors of Gynecology & Obstetrics
Mary Littlemeyer	Association of American Medical Colleges
David L. Rabin, M.D.	Association of Teachers of Preventive Medicine
Carolyn B. Rabinowitz, M.D.	Association of Academic Psychiatry
Thomas Stair, M.D.	Society for Teachers of Emergency Medicine
Stefan Stein, M.D.	American Association of Directors of Psychiatric Residency Training
Thomas G. Webster, M.D.	Association for Academic Psychiatry

CHALLENGES IN RESEARCH

Moderators: Bernadine H. Bulkley, M.D. Room: Farragut  
Jack L. Kostyo, Ph.D.

CAS Staff: Lucy Theilheimer

Participants:

- |                              |  |
|------------------------------|--|
| Kenneth I. Berns, M.D.       | Association of Medical School Microbiology                       |
| Robert M. Blizzard, M.D.     | Association of Medical School Pediatric Department               |
| David M. Brown, M.D.         | Academy of Clinical Laboratory Physicians & Scientists           |
| Thomas C. Cole, M.D.         | Association of Academic Physiatrists                             |
| John J. Gartland, M.D.       | American Academy of Orthopaedic Surgeons                         |
| Kenneth V. Iserson, M.D.     | Society of Teachers of Emergency Medicine                        |
| Thomas J. Kennedy, Jr., M.D. | Association of American Medical Colleges                         |
| Caliann G. Lum, M.D.         | Association for Academic Surgery                                 |
| Oscar D. Ratnoff, M.D.       | Association of American Physicians                               |
| Benjamin D. Schwartz, M.D.   | American Federation for Clinical Research                        |
| Larry B. Silver, M.D.        | Association of Academic Psychiatry                               |
| William L. West, M.D.        | American Society for Pharmacology & Experimental<br>Therapeutics |

Document from the collections of the AAMC Not to be reproduced without permission



**1984 SPRING MEETING**  
**of the**  
**COUNCIL OF ACADEMIC SOCIETIES**

April 10–11, 1984  
Washington, D.C.

What are the Issues and Challenges  
Facing Medical School Faculty  
in the Next Five Years?

**Program and Registration Information**

1984 SPRING MEETING  
of the  
COUNCIL OF ACADEMIC SOCIETIES

April 10-11, 1984  
Washington, D.C.

PROGRAM

*What are the Issues and Challenges  
Facing Medical School Faculty in the  
Next Five Years?*

Tuesday, April 10th

10:00 am - 12:30 pm  
PLENARY SESSION

Keynote Address

*Kern Wildenthal, M.D., Ph.D.  
Dean, University of Texas  
Southwestern Medical School at Dallas*

What are the Challenges in Medical Education?

*Victor R. Neufeld, M.D., F.R.C.P.(C)  
Chairman, The M.D. Program  
McMaster University*

What are the Challenges in Research?

*Ronald W. Estabrook, Ph.D.  
Professor of Biochemistry,  
University of Texas  
Southwestern Medical School at Dallas*

What are the Challenges in Patient Care?

*Kenneth I. Shine, M.D.  
Chairman, Department of Medicine  
UCLA School of Medicine*

What are the Challenges in Medical School/Medical  
Center Governance?

*Edward J. Stemmler, M.D.  
Dean  
University of Pennsylvania School of Medicine*

12:30 - 2:00 pm  
LUNCHEON

2:00 - 4:00 pm  
WORKSHOPS

(Moderated by  
CAS Administrative Board Members)

The Challenges in Medical Education

*Moderators: Frank C. Wilson, M.D.  
Harold S. Ginsberg, M.D.*

The Challenges in Research

*Moderators: Bernadine H. Bulkley, M.D.  
Jack L. Kostyo, Ph.D.*

The Challenges in Patient Care

*Moderators: Joseph E. Johnson, III, M.D.  
Frank G. Moody, M.D.*

The Challenges in Institutional Governance

*Moderators: David H. Cohen, Ph.D.  
Virginia V. Weldon, M.D.*

4:00 - 5:00 pm  
CONSENSUS SESSION

Representatives will reconvene to review con-  
clusions reached during workshops and for an  
overall discussion of the challenges identified.

5:00 - 7:00 pm  
RECEPTION

Wednesday, April 11th

8:30 - 11:30 am  
DISCUSSION SESSION

*Meeting the Challenges: The Role of the Council  
of Academic Societies and Its Members*

Following a day devoted to identifying the major  
issues and challenges that will confront medical  
school faculty in the next five years, the morning  
discussion will center on how these areas of con-  
cern can be addressed in an effective and timely  
manner. The discussion will focus on ways in  
which academic societies can assist their members  
in carrying out their education, research, and  
patient care missions and on how the Council of  
Academic Societies can serve to enhance these  
efforts. Strategies will be considered to maximize  
faculty participation in CAS and to improve com-  
munication between the AAMC, the Represent-  
atives to the CAS, and the members of their  
respective societies. Challenges identified,  
organizational issues raised, and strategies  
adopted at this CAS Spring Meeting will form the  
basis of a planning paper for future CAS activities.

HOTEL RESERVATIONS

Please complete the enclosed reservation card and  
return **to the Washington Hilton** by March 12.

MEETING REGISTRATION

Please tear off and complete the meeting registra-  
tion form and return **by March 26** to:

Ms. Cecelia Hannon  
Division of Biomedical Research  
and Faculty Development  
AAMC  
One Dupont Circle, N.W. #200  
Washington, D.C. 20036

Questions may be directed to Ms. Hannon at  
202-828-0480.

*Please Print*

1984 CAS SPRING MEETING REGISTRATION FORM  
Please Enclose Registration Fee and Return by March 26

Name: \_\_\_\_\_ Society: \_\_\_\_\_

Address: \_\_\_\_\_

Please place a "1" next to your first choice discussion group and a "2" next to your second choice.

\_\_\_\_\_ Challenges in Medical Education

\_\_\_\_\_ Challenges in Patient Care

\_\_\_\_\_ Challenges in Research

\_\_\_\_\_ Challenges in Institutional Governance

To cover the costs of the luncheon and reception, a registration fee of \$20 is being charged. Please enclose a  
check made payable to "AAMC" with this registration form.