



ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

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**MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
SPRING MEETING**

March 15-17, 1989  
Sonesta Village Hotel  
Orlando, Florida

Orientation Session

A luncheon and orientation session for new CAS Representatives was held Wednesday afternoon, March 15. Presentations on their activities and responsibilities were given by Robert Petersdorf, M.D. and John Sherman, Ph.D. as well as the Vice Presidents or Associate Vice Presidents for all AAMC Operating Divisions. Ernst Jaffe', M.D. addressed the group on the governance, structure and operations of the CAS, and a panel discussion on the role of the CAS Representative was led by Joe Coulter, Ph.D. Other panelists were Drs. William Drucker, Myron Genel, and Gordon Kaye.

Plenary Session -- American Medical Faculty in the 21st Century: Challenges and Responsibilities

The keynote address, "The Demographics of Our Faculties: Who Will They Be and What Will They Do?" was presented by David R. Challoner, M.D., Vice President for Health Affairs at the University of Florida. He presented very striking data to support the thesis that there would be an inadequate number of researchers in the 1990s to produce the current quality of biomedical research, noted the decreasing percentage of MDs and even PhDs with at least six months of postdoctoral research training, and commented on the decreasing percentage of younger faculty at medical schools with an increasing percentage of older faculty. He concluded, therefore, that medical schools would be unable to provide the current and projected needs in terms of research personnel, and might face crises in supplying their own staff needs. He suggested that more faculty with research experience be hired in the face of the decreasing supply and the aging of the faculty. Noting that enlarging faculty was unrealistic, he recommended retrenchment, not growth. Dr. Challoner proposed that graying faculty assume non-research roles, schools reevaluate their tenure policies, and that medical schools develop consortia to conserve research resources. Finally, he urged the medical schools to find and admit the best students and channel them to research-intensive schools. The less research-intensive medical schools should do clinical trials which would be less expensive in terms of equipment and would train better clinicians.

Dr. Jaffe's CAS Chairman's address, "Modern American Medicine: A Plea for Positive Thinking," reviewed the positive aspects of careers in medicine and in particular, in academic medicine. He expressed great concern about increasing incidents of misconduct in science and the high priority given in recent years to the financial rewards of medicine, rather than the altruistic rewards. Dr. Jaffe' urged the group to stop denigrating the profession and instead to

concentrate on inculcating moral values into medical students. He presented a model of medical education in which a broad liberal education would be required for medical students, and science training as a real introduction to clinical medicine would occur in the first two years of medical school. The ideal educational track would be a 4 year liberal arts program, 4 years of biomedical education and one year of rotating internship for the M.D. degree, then further specialty or subspecialty training. He also expressed support for the revitalization of "pay back" schemes, in which financial aid for senior medical students and early graduate training is repaid by practice in an underserved area. A similar program for Ph.D. researchers to teach or work in industry should also be available.

Itzhak Jacoby, Ph.D. reported to the CAS on the Institute of Medicine Study of Physician Manpower Requirements of the Veterans Administration, which he directs. The very pervasive impact of the Veterans Administration on American medicine has been an important finding of the Study Committee to date. The findings and conclusions of the Committee are expected to be available in about one year, and Dr. Jacoby strongly encouraged the CAS to provide input and suggestions to the Committee. VA hospitals are often an important resource in individual communities. In 1984, the Veterans Administration set standards for all professions other than physicians in their facilities, but did not have the information necessary to set physician standards. Coupled with questions being raised by the Office of Management and Budget about physician manpower at the VA, internal VA concerns led to the development of the IOM study. The IOM Committee is chaired by Dr. Challoner, and its members include both VA and non-VA clinicians as well as economists. Panels have been set up to address Methodology, Affiliations, Physician Extenders (e.g., nurse practitioners), and Specialties. Louis Kettel, M.D., Associate Vice President for Academic Affairs at the AAMC, serves on the Affiliations Panel. Dr. Jacoby discussed the methodology that the study hopes to use, and stressed the pivotal principles that Veterans Administration facilities provide care and must be properly staffed to render such care; and that where teaching and research are occurring, these activities are interwoven and inseparable, and often are specific to the medical school/VA medical center. He will report back to the CAS at its Annual Meeting in October.

"Closing the Gap Between Medical Education and Medical Practice," was the title of the thought-provoking address given by Donald W. Light, Ph.D., Professor of Social Psychiatry and Sociology at the University of Medicine and Dentistry of New Jersey and Rutgers University. Dr. Light called the 1970s the "golden era of medical education," and cautioned that what is being perceived as drops in applicant pools and NIH funding are actually returns to historically normative levels. Dr. Light questioned the group about what medical schools actually do. Society believes that medical schools train doctors, but in fact, they are becoming health service conglomerates and biotechnology research centers. They serve society's greater interests, but have a poor reputation for serving the needs of public health. Dr. Light, in informally surveying the CAS membership, received widely varying answers to his questioning whether medical schools need to do research to educate practicing physicians. He expressed a concern that undergraduate and graduate medical education have been separated in ways that have more to do with turf than need, and wondered whether anyone at a specific medical school was actually hired to teach medical students instead of doing research or providing practice income.

Dr. Light cited the "buyers' revolt" which has occurred in all segments of the American economy in recent years. Those who are paying for medical education and medical care want to know how their money is spent and see a value for it. He presented the thesis that medical schools and academic medical centers have changed less than any other industry in response to the buyers' revolt. Since Medicare and state governments have begun cutting their financial support for medical education, medical schools depend increasingly on practice and research income, thus giving education a lower priority. He also stated that researchers are under such pressure to bring in research dollars that they no longer have time to perform the job (education) for which they are paid their base salaries. The changes in housestaff hours wrought by New York State have created incentives to train more primary care physicians and fewer specialists. Currently, 30% of all physicians are primary care physicians, but 70% of the population has primary care needs. To meet this need, primary care and clinical time must be appropriately rewarded and compensated. The reduction of Medicare rates invites exploitation and neglect of the poor. The expectations placed on physicians are to meet the needs of society, but when physicians treat the indigent, they do not bring in enough income to cover their overhead costs. The balance intended by Flexner has gotten out of equilibrium due to financial pressures. Fiscal cuts have left the old system of medical education intact but starving.

Dr. Light addressed other financial pressures on the medical profession, most notably the high debt rates of beginning physicians. He believes that such debts affect career choices and are creating social class discrimination for the medical school applicant pool. He suggested a voucher system for free medical education for all students in primary care. He also proposed comparative institutional studies of how students learn in research-intensive and non-research-intensive schools, with follow-up 10 to 15 years after their medical education is completed to see how both groups cope with the growing obsolescence of their education.

The CAS then broke into three discussion groups, fueled by the plenary speakers. "Is the triple threat academician obsolete?" was led by Dr. Jaffe' and Thomas C. King, M.D. "How do we recruit future faculty?" was led by Drs. Coulter and Genel, and "How should academic units in medical schools be organized?" was led by Douglas E. Kelly, Ph.D., Wilton Bunch, M.D., Ph.D., and Lewis Siegel, Ph.D.

The discussion group considering whether the triple threat academician is obsolete reached the consensus that at least a "double threat" is necessary to function in academic medicine. Whatever else one does, one must also teach. The concept of a three-cornered stool was long ago replaced by a four-cornered one, with the administrative/management role appearing early in the academic medical career, and remaining at least constant and perhaps increasing throughout the career. The sharing of information is an obligation of academic medicine, whether it be through publishing or presentations as well as in the classroom. Concern was expressed by the discussion group that the concept of peer review is lost in clinical research, and that clinical researchers are being judged by inappropriate standards in promotion and tenure decisions, as well as in research. Little or no preparation for the administrative, research and teaching roles is provided in medical school; MDs are trained for clinical practice only. There is a need to spend some effort on training future academicians for these

other roles and to foster role models. A great irony of academic medicine is that those who are good at one of these roles "get punished" for being good, i.e. the faculty member who is perceived as a good teacher gets more teaching assignments, and thus less opportunity and time for research. This is especially hard on good clinicians due to the pressure to produce income from practice. The group noted that the only way to reward teaching roles is through redistribution of current income, as new income sources are not likely to become available. A need was expressed to develop new academic tracks and get clear definitions of what the labels on such tracks mean. The group recommended that the CAS develop standard job titles for all disciplines. A second consensus reached was that if an individual cannot be a triple-threat, then it is incumbent upon the department chair to make certain the department covers all other functions. A way to effect measurable evaluation of teaching ability should be built into the system, so that good teachers, especially younger faculty members, may be rewarded, and assisted with their appointments and promotions. Great concern was expressed that young faculty are sometimes unfairly brought into a medical school to do work that will protect older faculty so they can participate in outside activities (such as CAS meetings). Medical schools need to be more forthcoming about assigning responsibilities, and compensating faculty accordingly.

The group considering issues of recruitment of future faculty raised the question of how you train and recruit people without knowledge of what role they are being trained to perform. This group acknowledged that individual faculty members may serve with various amounts of responsibility in the areas of teaching, service, research, and administration, but stated that no faculty member should be doing any of the other roles without teaching. Goals were set by this group with strategies for reaching them, as follows:

Goal 1. Make academic medical careers more attractive.

Strategies:

1. Evolve more control over lifestyles.
2. Aim recruitment at increasingly younger groups, especially high school students.
3. Deliver the message ourselves.
4. Encourage the AAMC and other medical groups to do better public relations.
5. Develop summer programs for high school students.
6. Close the gap in salaries between the private sector and academe.
7. Improve community affairs.
8. Develop special programs for women and minorities.
9. Increase NIH funding.

Goal 2. Prepare future faculty appropriately, especially for their role as educators.

Strategies:

1. Develop better role models.
2. Develop "how to teach" courses or programs. It is probably necessary to develop separate ones for specific disciplines, rather than relying on a generic program for all specialties.

3. Ask the LCME to consider the education of teachers in the accreditation process.
4. Improve communication with professional educators.
5. Evaluate teaching in promotion and tenure decisions, considering the outcomes of teaching.

The group which considered the organization of academic units in medical schools first raised several questions: What patterns of reorganizations are emerging? Does reorganization favor research at the expense of teaching? Is reorganization driven by money and is that acceptable? Can faculty serve both traditional structure and interdepartmental programs? and To what extent does technology transfer drive reorganization? Dr. Siegel presented the reorganization plan followed by Duke University, which was driven by faculty concerns. He feels that it has been sensitive to both teaching and research, but acknowledged that Duke had enough financial security to institute changes which resulted in the hiring of additional basic science faculty. Dr. Bunch presented a rationale for retaining the traditional structure at the University of South Florida. The USF decision in response to the proposed development of a cancer center and the formation of an oncology department. Reasons for the decision not to reorganize included financial considerations and continuity of interest. The University of Alabama-Birmingham model was also discussed, as it has maintained traditional departments while also fostering supradepartmental centers, with administrative chores shared by the traditional departments. This plan provides much flexibility. This group reached ten points of consensus:

1. Any reorganization must serve both education and research.
2. Any reorganization must retain or promote the integrity of interaction between basic and clinical sciences.
3. Reorganization should not be driven by a quest for money or new technology.
4. Reorganization can be used to respond to national research needs, but can also be done by forming clusters (e.g., UAB).
5. Reorganization can extend beyond the bounds of the medical school, but is apt to get out of control if it extends too far beyond those bounds.
6. There is danger in increasing the number of departments in a medical school, as it strains administration and accountability.
7. Technology transfer has the potential to drive reorganization, but it has not yet done so.
8. Efforts to reorganize may add to the overload of pressures already felt by academicians.
9. The uniqueness of the institution must be considered in reorganization, especially with regard to faculty morale.
10. The AAMC should assess current reorganization activities.

## Business Meeting

### I. Chairman's Report - Ernst R. Jaffe', M.D.

Due to the wealth of riches on the agenda, no report was given.

### II. President's Report - Robert G. Petersdorf, M.D.

Dr. Petersdorf stated that executive staff recruitment is now complete with the appointment of Douglas E. Kelly, Ph.D. as AAMC's new Associate Vice President for Biomedical Research. He announced that the AAMC has been through a strategic planning process, highlighted initiatives in each operational division, and outlined the plans for the new AAMC headquarters building.

### III. Action and Discussion Items

A. Minutes -- The minutes of the 1988 Annual Meeting were approved as submitted.

#### B. Membership Applications

Lewis Aronow, Ph.D. led the discussion of the membership application of the American College of Clinical Pharmacology. The CAS Administrative Board and Executive Council had previously approved this application.

**ACTION:** The CAS unanimously voted to approve the American College of Clinical Pharmacology for membership.

Joel Sacks, M.D. presented the application of the Association of Academic Health Science Library Directors, which had also been previously approved by the CAS Administrative Board and Executive Council.

**ACTION:** The CAS unanimously approved the membership application of the AAHSLD.

Final action on both membership applications will be taken by the AAMC Assembly at the Annual Meeting in October.

#### M. Declining Autopsy Rates -- Vivian W. Pinn-Wiggins, M.D.

Dr. Pinn-Wiggins advised the CAS that she, on behalf of the Association of Pathology Chairmen, met with senior staff members of the AAMC to discuss and clarify possible roles for the AAMC in addressing the problem of declining autopsy rates. The pathologists are considering various strategies, and she will bring progress reports back to the CAS as they develop.

#### L. AAMC Ad Hoc Committee on Misconduct and Conflict of Interest -- David H. Cohen, Ph.D., Chair

This committee was formed to review and adapt the Framework Document for Institutional Policies and Procedures to Deal with Misconduct in Science for the academic medicine community. The document on misconduct recently produced by

the Institute of Medicine has not yet been reviewed by the Committee, but it plans to do so since it has recommendations for professional societies. As Congressional interest in issues of misconduct increased, so did the responsibilities of the Ad Hoc Committee. At an early Committee meeting, Dr. Diana Zuckerman, on the staff of Rep. Ted Weiss (D-NY) brought up the topic of conflict of interest, an area where the academic medical community has even greater exposure. The Ad Hoc Committee is beginning an effort to develop conflict of interest guidelines. Dr. Cohen reminded the CAS that perception is as important as reality on this issue.

G. Report from the CAS Working Group on an Educator/Scholar Award -- Douglas E. Kelly, Ph.D., Chair

This project developed from the need to provide recognition and research support for successful teachers. Various foundations will be approached for financial support.

C. AMA-FREIDA -- Beverley D. Rowley, Ph.D.

The FREIDA (Fellowship and Residency Electronic Interactive Database Access) system is essentially an electronic version of the Directory of Graduate Medical Education. The AMA is also working on developing an electronic vacancy bulletin board. Dr. Rowley gave a demonstration, using slides, of how the program will work.

D. Clinical Pharmacology Education: A Paradigm for Basic Sciences-based Education in the Clinical Years of Medical School -- Richard Weinshilboum, M.D.

This presentation was a follow-up to Dr. Weinshilboum's program at the 1987 CAS Annual Meeting. Sponsored by the Council on Medical Student Education in Clinical Pharmacology and Therapeutics, which consists of the American College of Clinical Pharmacology, the American Society for Pharmacology and Experimental Therapeutics, the American Society for Clinical Pharmacology and Therapeutics, and the Association for Medical School Pharmacology, this project is working to enhance medical student education in pharmacology. Dr. Weinshilboum raised the question of how medical education includes disciplines that do not fit into the traditional curriculum, and how the AAMC can define operational techniques to deal with bridge disciplines. The pharmacology societies formally requested that the AAMC appoint a Council of Academic Societies-Group on Medical Education task force to deal with this issue. Dr. Weinshilboum elaborated on the need to prepare young physicians to handle new drugs and changing information on drugs, and encouraged that medical school curricula change to accommodate emerging disciplines.

E. AAMC Committee on Governance and Structure -- D. Kay Clawson, M.D.

In the 25 years since the Coggeshall Report was implemented, no basic change has occurred in the AAMC's governance and structure. Important players in medical education have no voice in the AAMC, and a committee consisting of the 5 immediate past Chairs, and the present Chair and Chair-Elect was formed to evaluate the current structure. John Colloton chairs this Committee, and Dr. Sherman staffs it. The Committee expects to produce a report which will be acted

upon at the Annual Meeting in October. Among the questions it will consider are whether the name of the AAMC is still appropriate and reflective of the constituency, and if other groups such as residents, health science vice presidents, graduate and continuing medical educators, postdoctoral research trainees, and research administrators should have AAMC representation. Concern was expressed by various CAS Representatives that creating new Councils for Vice Presidents and Residents would diminish the role of faculty, and give high impact to administrators, and it was suggested that the Vice Presidents join with the Deans to form a Council of Institutions to replace the Council of Deans. Dr. Clawson stated that residents would probably join the Council of Teaching Hospitals just as the Organization of Student Representatives relates to the Council of Deans. Input from CAS Representatives and societies was solicited.

F. CAS Nominating Committee -- Joe Coulter, Ph.D., Chair

Dr. Coulter reminded the CAS that the Nominating Committee will be meeting via conference call in May and encouraged anyone who would like to submit a nomination to do so by April 25. Members of the Nominating Committee are:

Joe Coulter, Ph.D., Chair, Society for Neuroscience and University of Iowa  
Ernst R. Jaffe', M.D., American Society of Hematology and Albert Einstein  
College of Medicine

Gordon Kaye, Ph.D., American Association of Anatomists, and Albany  
Medical College

Jack L. Kostyo, Ph.D., American Physiological Society and University  
of Michigan

Barbara McLaughlin, Ph.D., American Society for Cell Biology and University  
of Louisville

Norman Snow, M.D., Association for Surgical Education and Cleveland  
Metropolitan General Hospital

Paul Van Arsdel, M.D., American Academy of Allergy and Immunology and  
University of Washington

G. Report from the CAS Working Group on Faculty Development and Evaluation -  
- Joe Coulter, Ph.D., Chair

Dr. Coulter has met with senior AAMC staff to discuss the possibility of undertaking a project to address faculty development and evaluation. Writing of a document with guidelines for faculty development and evaluation is under consideration. Dr. Coulter solicited input from CAS Representatives on this project.

Report from the CAS Working Group on Discontinuities in Medical Education -  
- Frank G. Moody, M.D., Chair

This group recommends that there be a central coordinating body with authority over the entire process of medical education to include graduate medical education; that the AAMC assist a few selected medical schools in setting up and testing the advantages of the Ebert-Ginzberg six year curriculum; and that the AAMC encourage the medical schools, and the accrediting and certifying bodies for graduate medical education, to transform the fourth year of medical school into a rotating internship.



H. AAMC Strategic Plan -- John F. Sherman, Ph.D.

The AAMC has developed a strategic plan over the last several months, with new initiatives for each operational division. The format of the document was explained and the input of CAS Representatives requested.

I. Legislative Update -- Richard Knapp, Ph.D.

Dr. Knapp reviewed the ways the AAMC Office of Government Relations approaches its assignment, and discussed the value of its becoming an important source and resource for Congressional and Executive Branch staff. The fetal tissue and fetal research document produced by the AAMC last year has been very important in government relations work. Documents will be produced in the near future on research training and the indirect medical education subsidy. A public policy column is appearing in Academic Medicine, and authors for the first few months include Reps. Waxman, Stark, Dingell, and Sens. Burdick and Cranston.

Dr. Knapp explained the interaction between the Office of Government Relations and the various AAMC program staff. Major issues facing this community in the coming months include Veterans Administration appropriations, indirect medical education payments from Medicare, and NIH/ADAMHA appropriations. On VA appropriations, a group called Friends of the VA has been formed. Fifty-five organizations have endorsed its funding recommendations to date, and letters from Deans whose schools have VA affiliations have been generated. Members of the Council of Deans have testified before Congress on VA appropriations in recent months. Rep. Traxler met with the COD Administrative Board in February, about this important issue. Data produced by AAMC's Division of Clinical Services helped raise the ProPAC recommendation on indirect medical education payments from Medicare from 4.4% to 6.6%. A pink (action) memorandum was recently mailed to CAS, COD and COTH members on this subject, and Dr. Knapp's office will be following up with telephone calls next week to insure that letters are going out to Congress on this issue.

The APHIS regulations on animal welfare appeared in the Federal Register March 15. Academic medicine can anticipate major problems with these. CAS members will be asked to be active as this issue develops.

David Moore described the Ad Hoc Group on Medical Research Funding, noting that it is the AAMC's and the research community's major effort on the annual issue of funding for the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. Two separate issues in which the CAS should be involved are the budget resolution and appropriations. Hearings on the budget resolution are underway. The AAMC is working with the Coalition for Health Funding and the National Health Council to develop appropriate budget levels. A draft letter with lists of House and Senate Budget Committee members was distributed, and CAS Representatives were urged to write both the Budget Committee members and their own Congressman and Senators as soon as possible. On appropriations, the Ad Hoc Group brochure will be published in the very near future. It is directed at Congress, and Mr. Moore encouraged all CAS societies to endorse the Ad Hoc Group recommendations. An organization called Research! America has been formed, with former Senator Lowell Weicker as its director.

Its purpose is a public education campaign to raise the level of awareness and interest in medical research, but it is currently in a formative stage.

J. AAMC Task Force on Physician Supply -- Joseph Keyes, J.D.

The Physician Supply Task Force was appointed in January 1987 with Daniel Tosteson, M.D. as its Chair. Chairs of the four committees are Drs. Farber, Rabkin, Moy, and Corn, and the subjects of those groups are medical student education, specialty distribution, foreign medical graduates and quality control, and training of biomedical scientists, respectively. The recommendations of the task force are complete and the final report will be forthcoming. No targets for numbers of physicians were recommended, as there is no reliable way to predict demand. It is expected that there will be an abundance of physicians, and the physician/population ratio will likely be double that of the 1960s. The recommendations are:

1. Quality, not quantity, should be top priority for entering medical school classes. Schools are encouraged to limit the number of acceptances rather than reduce standards.
2. A recruitment campaign should be begun.
3. Efforts should be undertaken to increase underrepresented minorities, preserve the gains made in recent years, and expand the pool of minority applicants. The Task Force recommended that the medical education community work with schools, back to the primary school level, in accomplishing this goal.
4. Requirements for national service should be investigated.
5. Health services research was recommended, particularly in developing indices of overdoctoring, and whether seeing fewer patients will harm a physician's ability to maintain his or her skills.
6. No recommendations were made on the number of physicians per specialty.
7. Program size determinations should be made in consideration of national needs.
8. U.S. licensure should be limited to those who complete accredited residency programs.
9. Foreign medical graduates' acceptance into accredited residency programs should be conditional on passage of the ECFMG. Spoken English and clinical skills are essential for acceptance.
10. The International Medical Scholars Program should be developed.
11. The training of biomedical scientists was endorsed as equal in importance to the training of physicians and provision of patient care.

K. AAMC Framework Document for Institutional Policies and Procedures to Deal with Misconduct in Science -- Allan Shipp

This document was developed by an interassociation working group of higher education associations, FASEB, the American Society of Microbiology and AAMC. It provides guidance for institutions on how to handle allegations of misconduct, meets current regulatory requirements, and anticipates future regulation. The AAMC version of the Framework document includes a section on preventing

misconduct. The final document will be mailed out to the AAMC constituency in the next two weeks.

N. Medicare Proposed Regulations on Payment for Physician Services Furnished in Teaching Settings -- Joyce V. Kelly, Ph.D.

A memorandum requesting action on the draft regulations was mailed to the AAMC constituency in late February. It appears that HCFA has relaxed attending physician criteria for billing fees for all outpatient services, including family practice and emergency medicine. Concern was expressed about the proposed offset of practice plan income returned to the provider, against allowable Part A costs. The offset is conditional depending upon the relationship between the hospital, medical school, and practice plan. Detailed technical questions on these regulations should be addressed to Robert D'Antuono of the AAMC staff, who is working closely with HCFA to elicit the intent of the regulations. These regulations are expected to be implemented within the next six months. There was a meeting March 6 with Washington-based physician organizations, including the American Society of Internal Medicine and the American Medical Association, to coordinate community response and understanding. Comment letters are due at HCFA on April 10, and a group chaired by Hiram Polk, M.D., will meet on March 23 to help develop the AAMC comment letter.

O. Proposed Regulations on Medicare's Payment for Direct Graduate Medical Education (GME) Costs -- Joyce V. Kelly, Ph.D.

These proposed regulations affect Medicare Part A payments for direct GME costs, including stipends and fringe benefits for house officers, salaries of supervising physicians, and educational overhead. Essentially, the regulations provide for HCFA reimbursement of each provider's own 1984 historical costs per resident, adjusted for inflation. Dr. Petersdorf issued blue and pink memoranda on October 13 and November 9, 1988, respectively, calling members' attention to a number of technical issues in calculating costs (the numerator of the ratio) and counting residents (the denominator of the ratio). Final regulations are expected shortly. HCFA has also expressed interest in the wide variation among hospitals in their reported direct costs per resident. The AAMC recommends that providers examine their own reported costs compared to the 1984 mean value of \$53,500. Hospitals with 1984 costs considerably above this amount may be at risk. In all activities, AAMC staff are guided by the principle that third party payers continue to support medical education as an investment in the future of health care practitioners.

P. Uniform Pathway to Licensure -- Robert Volle, Ph.D.

The Task Force on Uniform Examination for Licensure includes the Federation of State Medical Boards, Education Commission for Foreign Medical Graduates, National Board of Medical Examiners, American Medical Association, AAMC, Accreditation Council for Graduate Medical Education, National Board of Osteopathic Medical Examiners, and U.S. Department of Health and Human Services. The current dual pathway system is:

For graduates of LCME-accredited schools of medicine:

NBME Part I

NBME Part II

MD degree plus one year of graduate medical education

NBME Part III

Or, MD degree

FLEX I

FLEX II

The National Board certificate is not recognized in Texas, Louisiana, Puerto Rico and the Virgin Islands, where the FLEX examination is used instead. Twenty percent of all medical students take the FLEX examination and 80% take NBME.

For graduates of non-LCME-accredited schools:

FMGEMS I

or

NBME Part I

FMGEMS II

or

NBME Part II

MD degree

other ECFMG requirements

ECFMG certificate

graduate medical education

FLEX I

FLEX II

The proposed single pathway for LCME or non-LCME graduates would be:

Step I (NBME Part I)

Step II (NBME Part II)

MD or ECFMG certificate

graduate medical education, minimum one year

Step III

Over the next six to seven months, this plan will be announced around the country, and input solicited. The NBME Board will review the proposal at its annual meeting later this month, and if approved, will become official policy in March of 1990. A preliminary review indicates no impairment of LCME and ACGME work with this plan.

Dr. Jaffe' thanked the presenters, announced attendance, and concluded the meeting with a traditional Irish benediction for St. Patrick's Day.

COUNCIL OF ACADEMIC SOCIETIES  
Spring Meeting Registration  
March 15-17, 1989  
Orlando, Florida

<u>Society</u>	<u>Representative</u>
Academy of Clinical Laboratory Physicians and Scientists	James Winkelman
Ambulatory Pediatric Association	Steven P. Shelov
American Academy of Allergy and Immunology	
American Academy of Neurology	Rosalie A. Burns
American Academy of Ophthalmology	Joel Sacks Bronwyn Bateman
American Academy of Orthopaedic Surgeons	Wilton Bunch
American Academy of Physical Medicine and Rehabilitation	Arthur E. Grant
American Association for the Study of Liver Diseases	
American Association for the Surgery of Trauma	William R. Drucker
American Association for Thoracic Surgery	Thomas C. King
American Association of Anatomists	Gordon Kaye Roger Markwald Jerome Sutin
American Association of Chairmen of Departments of Psychiatry	Jerry Wiener
American Association of Chairmen of Plastic Surgery	
American Association of Directors of Psychiatric Residency Training	Stefan Stein George Ginsberg
American Association of Neurological Surgeons	
American Association of Pathologists	
American Association of Plastic Surgeons	Hal G. Bingham
American College of Neuropsychopharmacology	Arthur Prange, Jr.

American College of Obstetricians and Gynecologists	William E. Easterling, Jr.
American College of Physicians	Frank Davidoff
American College of Psychiatrists	
American Federation for Clinical Research	J. Sanford Schwartz
American Gastroenterological Association	John T. Farrar
American Geriatrics Society	
American Neurological Association	
American Orthopaedic Association	
American Pediatric Society	Myron Genel
American Physiological Society	George Hedge
American Psychiatric Association	Herbert Pardes
American Society for Biochemistry and Molecular Biology	Kurt Ebner
American Society for Cell Biology	George Pappas Barbara McLaughlin
American Society for Clinical Investigation	
American Society for Clinical Nutrition	Roland Weinsier
American Society for Clinical Pharmacology and Therapeutics	Richard Weinshilboun
American Society for Pharmacology and Experimental Therapeutics	Lewis Aronow William West
American Society of Hematology	Harry Jacob Ernst R. Jaffe'
American Society of Human Genetics	Elizabeth M. Short
American Surgical Association	Judson Randolph
Association for Academic Psychiatry	Louis Rittelmeyer Carolyn B. Robinowitz
Association for Academic Surgery	John G. Hanks
Association for Medical School Pharmacology	Alan Niemes

Association for the Behavioral Sciences and Medical Education	Beverley D. Rowley DeWitt Baldwin
Association for Surgical Education	Norman Snow
Association of Academic Departments of Otolaryngology	Warren Y. Adkins Robert I. Kohut
Association of Academic Psychiatrists	Dorothea D. Glass
Association of American Physicians	
Association of Anatomy Chairmen	Robert D. Yates Douglas E. Kelly
Association of Anesthesiology Program Directors	Robert M. Epstein
Association of Chairmen of Departments of Physiology	Mordecai Blaustein
Association of Departments of Family Medicine	Thornton Bryan Harry E. Mayhew
Association of Directors of Medical Student Education in Psychiatry	Irwin Hassenfeld
Association of Medical School Departments of Biochemistry	Larry P. Solomonson
Association of Medical School Microbiology Chairmen	Kenneth Berns
Association of Medical School Pediatric Department Chairmen	
Association of Orthopaedic Chairmen	
Association of Pathology Chairmen	Aubrey Hough Vivian Pinn-Wiggins
Association of Pediatric Program Directors	
Association of Professors of Dermatology	
Association of Professors of Gynecology and Obstetrics	Douglas R. Knab
Association of Professors of Medicine	Harold J. Fallon
Association of Program Directors in Internal Medicine	
Association of Teachers of Preventive Medicine	

Association of University Anesthetists

Milton Alper  
C. Philip Larson, Jr.

Association of University Professors  
of Neurology

Association of University Professors  
of Ophthalmology

Association of University Radiologists

A. Everette James, Jr.  
Paul J. Friedman

Central Society for Clinical Research

Child Neurology Society

Gwendolyn Hogan

Endocrine Society

Plastic Surgery Educational Foundation

Plastic Surgery Research Council

Society for Health and Human Values

Rita Charon

Society for Neuroscience

David H. Cohen  
Joe Dan Coulter

Society for Pediatric Research

Society for Surgery of the Alimentary Tract

Henry Pitt

Society of Academic Anesthesia Chairmen

Burton Epstein  
S. Craighead Alexander

Society of Chairmen of Academic Radiology  
Departments

Society of Critical Care Medicine

S. G. Hershey  
H. David Reines

Society of Gynecologic Investigation

Society of Surgical Chairmen

Frank G. Moody

Society of Teachers of Emergency Medicine

Glenn C. Hamilton  
Richard Nowak

Society of Teachers of Family Medicine

Alfred O. Berg

Society of University Otolaryngologists

Lanny Garth Close  
Lee A. Harker

Society of University Surgeons

Douglas W. Hanto



Society of University Urologists

David G. McLeod

Surgical Infection Society

David N. Herndon

Thoracic Surgery Directors Association

University Association for Emergency Medicine

Richard C. Levy

TOTAL: 61 Societies

81 Representatives



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ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

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**AGENDA**

**COUNCIL OF ACADEMIC SOCIETIES**

**SPRING MEETING**

March 15-17, 1989  
Sonesta Village Hotel  
Orlando, Florida

**FUTURE MEETING DATES**

**AAMC Annual Meeting  
Washington, D. C.**

**October 28-November 2, 1989**

**CAS Spring Meeting  
San Antonio, Texas**

**March 14-16, 1990**

**AAMC Annual Meeting  
San Francisco, California**

**October 20-25, 1990**

## SCHEDULE

### Council of Academic Societies Spring Meeting March 15-17, 1989

#### Wednesday, March 15, 1989

11:30 a.m. - 12:30 p.m.	Registration	Conference Center Foyer
12:30 - 1:30 p.m.	Luncheon	Azalea Room
1:30 - 4:30 p.m.	Orientation for new CAS Representatives	Oleander A
6:00 - 7:00 p.m.	Keynote Speaker David R. Challoner, M.D.	Oleander A
7:00 - 8:00 p.m.	Reception	Pool/Veranda Area
8:00 p.m.	Dinner	Oleander Ballroom

#### Thursday, March 16, 1989

8:00 a.m.	Continental Breakfast	Preassembly
8:30 - 10:15 a.m.	Council Plenary Forum	Oleander Ballroom
10:15 a.m. - 12:30 p.m.	Breakout Groups Triple-threat Academician Recruit future faculty Organize academic units	Orchid Room Azalea Room Oleander Ballroom
6:00 - 7:00 p.m.	Discussion Group Reports	Oleander A
7:00 - 8:00 p.m.	Reception	Pool/Veranda Area
8:00 p.m.	Dinner	Oleander Ballroom

#### Friday, March 17, 1989

8:00 a.m.	Continental Breakfast Sign-in for Business Meeting	Preassembly
8:30 a.m. - 1:00 p.m.	CAS Business Meeting	Oleander Ballroom

**ORIENTATION**

**FOR NEW CAS REPRESENTATIVES**

**SECTION A**

**ORIENTATION FOR NEW REPRESENTATIVES**

Council of Academic Societies Spring Meeting  
12:30 - 4:30 p.m.  
March 15, 1989  
Oleander A  
Sonesta Village Hotel  
Orlando, Florida

**AGENDA**

- I. Luncheon -- Azalea Room
- II. Welcome and Opening Remarks  
Ernst R. Jaffe', M.D., CAS Chair  
Robert G. Petersdorf, M.D., AAMC President
- III. History of the AAMC  
John F. Sherman, Ph.D., Executive Vice President
- IV. The AAMC Governance Structure  
Robert G. Petersdorf, M.D.
- V. Structure of the AAMC
  - A. Office of the President.....1  
John F. Sherman, Ph.D.
  - B. Office of Government Relations.....3  
David B. Moore, Assistant Director
  - C. Division of Academic Affairs  
Louis J. Kettel, M.D., Associate Vice President
  - D. Division of Clinical Services.....handout  
Joyce Kelly, Ph.D., Associate Vice President
  - E. Division of Institutional Planning and Development  
Joseph Keyes, J.D., Vice President and General Counsel
  - F. Division of Communications.....handout + 7  
Elizabeth Martin, Vice President
  - G. Division of Minority Health, Disease Prevention and Health  
Promotion  
Herbert Nickens, M.D., Vice President

H. Division of Biomedical Research  
Thomas E. Malone, Ph.D., Vice President

VI. History of the Council of Academic Societies.....8

VII. Ad Hoc Group for Medical Research.....26  
Other cooperative and coalition efforts  
David B. Moore

VIII. The CAS Governance, Structure and Operations

A. CAS Administrative Board, Nominating Committee, Representation  
on AAMC Ad Hoc and Standing Committees and Terms of Office  
Ernst R. Jaffe', M.D.

B. The role of the CAS Representative  
Joe Dan Coulter, Ph.D., CAS Chair-Elect  
William Drucker, M.D.  
Myron Genel, M.D.  
Gordon Kaye, Ph.D.



ASSOCIATION OF  
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LEGISLATIVE OBJECTIVES FOR 101ST CONGRESS

\*FEDERAL BUDGET COMMITMENTS

- achieve the Coalition for Health Funding recommendations for function 550 (health) in the budget resolution
- achieve positive mention of NIH, ADAMHA and health manpower programs in Budget committee instructions to appropriations committee
- achieve positive mention of Medicare market basket hospital payment increase and indirect medical education adjustment in Budget Committee instructions to Senate Finance Committee and House Ways and Means Committee

\*APPROPRIATIONS

- achieve NIH and ADAMHA appropriations at the level recommended by the Ad Hoc Group for Medical Research Funding
- oppose further reductions in health manpower support
- support increased funding of National Health Service Corps loan payment program
- achieve at least a \$600 million increase in the current services Veterans Administration medical care budget base
- support the VA appropriations recommendations of the Independent Service Organizations and the Friends of VA Medical Care and Research

\*MEDICARE

- achieve at least market basket price increase in hospital payments;
- continue indirect medical education adjustment at current level;
- continue direct medical education payments in current payment formulation;
- return capital reimbursement to full cost payment level;
- increase percentage of dollars devoted to outlier payments;
- increase physician prevailing charges at the full 1989 Medicare Economic Index;

12/2/88



\*MEDICAID

- continue to support expanded scope of mandatory benefits to a broader population of beneficiaries;
- special efforts should be made to increase the participation of pregnant women and children in low income families

\*BROADER HEALTH INSURANCE COVERAGE

- support employer based mandatory health insurance

\*SCIENTIFIC MISCONDUCT

- recommend this subject be addressed through regulatory approach currently being developed by the Department of Health and Human Resources
- resist efforts for specific involvement of the Office of the Inspector General

\*HEALTH RESEARCH FACILITIES

- support efforts to reestablish an NIH and ADAMHA program for the construction and modernization of health research facilities

\*PROTECTION OF ORIGINAL IDEAS

- support amendment of Freedom of Information Act to prevent disclosure of original ideas contained in research grant applications and progress reports submitted by investigators

\*TAXES

- restore full tax exemption for scholarships and fellowships
- support deduction of interest on loans used for educational expenses from income subject to federal tax
- support charitable deduction for gifts at appreciated value of property donated
- support extension of tax credit for businesses to fund the conduct of basic research in higher education institutions
- oppose further erosion of tax exempt bond authority

-oppose taxation of endowment income

-monitor closely developments with respect to the Unrelated Business Income Tax

\*USE OF ANIMALS IN RESEARCH

-resist initiatives which will result in decreased availability for responsible use of animals in research and education

\*FETAL RESEARCH

-follow progress of Congressional Biomedical Ethic's Advisory Committee's study of the waiver mechanism

-support use of aborted fetal tissue in research

\*DEFERMENTS ON STUDENT LOANS

-achieve at least three year deferments on all GSL loans

\*STUDENT LOAN DEFAULTS

-advocate policies which allow institutions with higher than average student loan defaults to continue participation in the HEAL and GSL programs as long as they have addressed any institutional problems that may be exacerbating defaults

\*MINORITY FACULTY RECRUITMENT

-support loan repayment and other mechanisms to increase minority participation in research and faculty positions

\*TRAUMA CARE

-support efforts to develop PHS administered block grants to support regional trauma care networks

\*IMMIGRATION

-support creation of a limited "special immigrant" classification for foreign nationals who have been offered faculty positions provided no equally-qualified citizens or permanent residents are available

\*MEDICAL AND HAZARDOUS WASTE

- assist in the development of rational policy regarding the tracking and handling of medical waste.
- monitor legislation and regulations regarding the generation, handling, transportation, storage, and treatment of medical and hazardous waste.

# ACADEMIC MEDICINE

Volume 12, Number 1, January 1987

The Journal of Medical Education  
 The Journal of Academic Medicine  
 The Journal of Health Services Administration  
 The Journal of Health Politics, Law and Ethics  
 The Journal of Health Economics  
 The Journal of Health Law, Ethics and Regulation  
 The Journal of Health Management and Practice  
 The Journal of Health Organization, Management and Practice  
 The Journal of Health Politics, Law and Ethics  
 The Journal of Health Economics  
 The Journal of Health Law, Ethics and Regulation  
 The Journal of Health Management and Practice  
 The Journal of Health Organization, Management and Practice

The world of academic medicine is changing—and the oldest journal devoted to the training of physicians is changing too. Beginning in January, the JOURNAL OF MEDICAL EDUCATION, which has served the medical education community for 63 years, becomes ACADEMIC MEDICINE. The Journal will have a distinctive new design and format and will publish a wider range of articles.

Approximately one-third of each issue will be devoted to invited articles on major issues affecting medical education, to be written by medical and government leaders and policy-makers. The journal will continue to devote a major portion of each issue to research reports, using an expanded, stricter reviewing system. ACADEMIC MEDICINE will also publish regular features on international medical education, informatics, innovations in medical education, and national policies and will

have a quarterly column of book reviews.

Four prominent members of academic medicine have volunteered to serve as associate editors: SHERMAN M. MELLINKOFF, M.D. (University of California, Los Angeles, School of Medicine) will oversee book reviews; DANIEL R. MASYS, M.D. (Lister Hill National Center for Biomedical Communications) will provide quarterly features on medical informatics; DAVID S. GREER, M.D. (Brown University Program in Medicine) will provide a quarterly feature on international medical education; and WAYNE K. DAVIS, PH.D. (University of Michigan Medical School) will coordinate a

monthly feature on innovations in medical education.

Seven distinguished scholars and administrators from the Washington, D.C.—Baltimore area have agreed to serve as consulting editors, giving advice and assistance in implementing policies and programs. The Editorial Board—13 faculty members and administrators representing all major components of academic medicine—will set general policy and give the editor specific assistance.

For more information about the editorial policy and content of the journal, write

Addaerie S. Caellegh, Editor, ACADEMIC MEDICINE, Association of American Medical Colleges, 1 Dupont Circle, N.W., Washington, D.C. 20036.

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## HISTORY OF THE COUNCIL OF ACADEMIC SOCIETIES

August G. Swanson, M.D.

The Council of Academic Societies held its first meeting 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.

In the early to mid-80s, the issues changed. Direct support for expansion of the nation's capacity for medical education was phased out in 1980. The medical care system underwent a major evolutionary change, stimulated in large measure by concerns about health care costs in both the public and private sectors. Rather than the traditional worry about a shortage of physicians, concerns began to be expressed about a potential excess. Federal support for biomedical research continued, but maintaining an appropriate level of support required a major effort (spanning the Ad Hoc Group for Medical Research Funding), and attempts to reorganize and politicize the National Institutes of Health and ADAMHA has remained a continuing threat. Today, 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 attempt to enter accredited residencies. Fewer than 50 percent succeed.

Changing issues and changing times require assessment of how the Council of Academic Societies (CAS) and the Association of American Medical Colleges should be positioned to continue their mission, which is to advance academic medicine, basic biomedical research, 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. 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

Ramada 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 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 part of a university community which itself is rapidly

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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 by 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 input. 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 University 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 three 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 AAMC 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 opportunities in research training have been major continuing concerns of the Council. The leadership provided by the combination of AAMC and CAS 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 and the American Academy of Pediatrics when dues were increased in 1973, the membership in CAS has grown steadily from 22 to 88 societies. Other issues of national policy that member societies have looked to the CAS for action on are the clinical laboratory improvement act, medical reimbursement of physicians in a teaching setting, amendment of the National Labor Relations Act to permit unionization of housestaff, 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 evaluation of medical students and medical education programs.

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 Report.

Increasing interest in having a "Washington presence" resulted in the formation of the Council of Academic Societies' Services Program from 1977 to 1987. The Association of Professors of Medicine, four neurological societies, and the AFCR were 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 in 1966 which established three Councils (Council of Deans, Council of Teaching Hospitals, CAS) 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 Organization of Student Representatives have developed a mode of operation that presents all matters to the Administrative Boards and the Executive Council 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 attached letter 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 major effort to address this informational flow was begun in 1988 with the Liaison Project. Each member of the CAS Administrative Board was assigned 7 societies as a "Liaison Group," and given the responsibility of regular contact with the CAS Representatives from those societies. Although it is too early to assess the long-term value of this program, early indications are that communication in both directions between the constituency and the leadership will be greatly enhanced.

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

COUNCIL OF ACADEMIC SOCIETIES MEMBERSHIP  
1989

Basic Sciences

**ANATOMY**

American Association of Anatomists  
American Society for Cell Biology  
Association of Anatomy Chairmen

**BEHAVIORAL SCIENCE**

Association for the Behavioral Sciences and Medical Education

**BIOCHEMISTRY**

American Society for Biochemistry and Molecular Biology  
Association of Medical School Departments of Biochemistry

**GENETICS**

American Society of Human Genetics

**MICROBIOLOGY**

Association of Medical School Microbiology Chairmen

**NEUROSCIENCE**

Society for Neuroscience

**PATHOLOGY**

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

**PHARMACOLOGY**

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

**PHYSIOLOGY**

American Physiological Society  
Association of Chairmen of Departments of Physiology

**PREVENTIVE MEDICINE**

Association of Teachers of Preventive Medicine

**Clinical Sciences**

**ANESTHESIOLOGY**

Association of Anesthesiology Program Directors  
Association of University Anesthetists  
Society of Academic Anesthesia Chairmen

**CRITICAL CARE**

Society of Critical Care Medicine.....

**DERMATOLOGY**

Association of Professors of Dermatology

**EMERGENCY MEDICINE**

Society of Teachers of Emergency Medicine  
University Association for Emergency Medicine

**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 for Academic Surgery  
Association for Surgical Education  
Society for Surgery of the Alimentary Tract  
Society of Surgical Chairmen  
Society of University Surgeons  
Surgical Infection Society

**INTERNAL MEDICINE**

American College of Physicians  
American Federation for Clinical Research  
American Gastroenterological Association  
American Society for Clinical Investigation  
American Society of Hematology  
Association of American Physicians  
Association of Professors of Medicine  
Association of Program Directors in Internal Medicine  
Central Society for Clinical Research

**MULTISPECIALTY**

American Academy of Allergy and Immunology  
American Association for the Study of Liver Diseases  
American Geriatrics Society  
American Society for Clinical Nutrition  
Endocrine Society  
Society for Health and Human Values

**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  
Society for Gynecologic Investigation

**OPHTHALMOLOGY**

American Academy of Ophthalmology  
Association of University Professors of Ophthalmology

**ORTHOPAEDICS**

American Academy of Orthopaedic Surgeons  
American Orthopaedic Association  
Association of Orthopaedic Chairmen

**OTOLARYNGOLOGY**

Association of Academic Departments of Otolaryngology  
Society of University Otolaryngologists/Head and Neck Surgeons

**PEDIATRICS**

Ambulatory Pediatric Association  
American Pediatric Society  
Association of Medical School Pediatric Department Chairmen  
Association of Pediatric Program Directors  
Society for Pediatric Research

**PHARMACOLOGY**

American Society for Clinical Pharmacology and Therapeutics

**PHYSICAL MEDICINE AND REHABILITATION**

American Academy of Physical Medicine and Rehabilitation  
Association of Academic Physiatriests

**PLASTIC SURGERY**

American Association of Chairmen of Plastic Surgeons  
American Association of Plastic Surgeons  
Plastic Surgery Educational Foundation  
Plastic Surgery Research Council

**PSYCHIATRY**

American Association of Chairmen of Departments of Psychiatry  
American Association of Directors of Psychiatric  
Residency Training  
American College of Psychiatrists  
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



**CHAIRMEN  
COUNCIL OF ACADEMIC SOCIETIES**

<u>Year</u>	<u>Name</u>	<u>Institution</u>
1967-68	Thomas D. Kinney, M.D.	Duke University
1969	Jonathan E. Rhoads, M.D.	University of Pennsylvania
1970	Daniel C. Tosteson, M.D.*	Duke University
1971	James V. Warren, M.D.	Ohio State University
1972	Sam L. Clark, M.D.	University of Massachusetts
1973	Robert G. Petersdorf, M.D.*	University of Washington
1974	Ronald W. Estabrook, Ph.D.	University of Texas at Dallas
1975	Jack W. Cole, M.D.	Yale University
1976	Rolla B. Hill, M.D.	SUNY-Syracuse
1977	A. Jay Bollet, M.D.	SUNY-Brooklyn
1978	Robert M. Berne, M.D.	University of Virginia
1979	Thomas K. Oliver, Jr., M.D.*	University of Pittsburgh
1980	Carmine D. Clemente, Ph.D.	UCLA
1981	Daniel X. Freedman, M.D.	University of Chicago
1982	David M. Brown, M.D.	University of Minnesota
1983	Frank C. Wilson, M.D.	University of North Carolina
1984	Robert L. Hill, Ph.D.	Duke University
1985	Virginia V. Weldon, M.D.*	Washington University
1986	David H. Cohen, Ph.D.*	Northwestern University
1987	Frank G. Moody, M.D.	University of Texas at Houston
1988	Douglas E. Kelly, Ph.D.	University of Southern California
1989	Ernst R. Jaffe', M.D.	Albert Einstein College of Medicine

\*Also served as AAMC Chair

COUNCIL OF ACADEMIC SOCIETIES  
ADMINISTRATIVE BOARD MEMBERS

<u>Name</u>	<u>Affiliations</u>	<u>Term</u>
Alexander, Eben	Bowman Gray American Association of Neurological Surgeons	1967
Alexander, S. Craighead	University of Wisconsin Society of Academic Anesthesia Chairmen	1987 -
Anderson, Philip C.	University of Missouri Association of Professors of Dermatology	1983-85
Aronow, Lewis	Uniformed Services University American Society for Pharmacology and Experimental Therapeutics	1987 -
Berne, Robert M. Chair 1977-78	University of Virginia American Physiological Society	1974-79
Berns, Kenneth I.	Cornell University Association of Medical School Microbiology Chairmen	1989 -
Bishop, F. Marion	University of Alabama Society of Teachers of Family Medicine	1974-80
Blizzard, Robert	University of Virginia American Pediatric Society	1972-74
Bollet, A. Jay Chair 1976-77	SUNY Downstate Association of American Physicians	1973-78
Braunwald, Eugene	Harvard Association of Professors of Medicine	1976-77
Brown, David M. Chair 1981-82	University of Minnesota Academy of Clinical Laboratory Physicians and Scientists	1977-83
Bryan, Thornton	University of Alabama Association of Departments of Family Medicine	1989 -
Bulkley, Bernadine H.	Johns Hopkins American Federation for Clinical Research	1981-84
Challoner, David	Indiana University American Federation for Clinical Research	1972-75

Clark, Sam, Jr. Chair 1971-72	University of Massachusetts American Association of Anatomists	1967-72
Clawson, D. Kay	University of Washington Association of Orthopaedic Chairmen	1973-75
Clemente, Carmine Chair 1979-80	UCLA American Association of Anatomists	1973-81
Cohen, David H. Chair 1985-86	SUNY Stony Brook Society for Neuroscience	1981-87
Cole, Jack W. Chair 1974-75	Yale University American Surgical Association	1973-76
Coulter, Joe Dan	University of Iowa Society for Neuroscience	1986 -
Curtis, Brian A.	University of Illinois American Physiological Society	1980-81
Dodge, Philip R.	Washington University Association of Medical School Pediatric Department Chairmen	1975-76
Eggers, G. W. N.	University of Missouri Association of University Anesthetists	1976-79
Eichna, Ludwig	SUNY Downstate Association of Professors of Medicine	1971-73
Estabrook, Ronald Chair 1973-74	University of Texas/Dallas American Society of Biological Chemists	1971-75
Feldman, Harry	SUNY Upstate Association of Teachers of Preventive Medicine	1967-70
Fitzgerald, Patrick	Cornell University American Association of Anatomists and Bacteriologists	1967-71
Forster, Robert	University of Pennsylvania American Physiological Society	1971-73
Freedman, Daniel X. Chair 1980-81	University of Chicago/Pritzker School American Association of Chairmen of Departments of Psychiatry	1975-82

Ganong, William F.	University of California/San Francisco Association of Chairmen of Departments of Physiology	1980-88
Genel, Myron	Yale University American Pediatric Society	1988 -
Ginsberg, Harold S.	Columbia University Association of Medical School Microbiology Chairmen	1983-85
Greenbaum, Lowell M.	Medical College of Georgia Association for Medical School Pharmacology	1979-83
Gregory, Charles	University of Texas/Dallas Joint Committee on Orthopaedic Research and Education Seminars	1969-73
Hamilton, Glenn C.	Wright State University Society of Teachers of Emergency Medicine	1988 -
Hill, Rolla B. Chair 1975-76	SUNY Upstate American Association of Pathologists and Bacteriologists	1972-77
Hill, Robert L. Chair 1983-84	Duke University American Society of Biological Chemists	1979-85
Hunninghake, Gary	University of Iowa American Federation for Clinical Research	1986-87
Jaffe', Ernst R. Chair 1988-89	Albert Einstein American Society of Hematology	1986-90
James, A. Everette	Vanderbilt University Association of University Radiologists	1984-87
Johns, T. R.	University of Virginia American Neurological Association	1978-82
Johnson, Joseph E.	Bowman Gray Association of Professors of Medicine	1979-85
Kaye, Gordon I.	Albany Medical College Association of Anatomy Chairmen	1985-86
Kelly, Douglas E. Chair 1987-88	University of Southern California American Association of Anatomists	1981-89

King, Donald W.	Columbia University American Association of Pathologists and Bacteriologists	1975-76
Kinney, Thomas Chair 1967-68	Duke University American Association of University Professors of Pathology	1967-71
Knobil, Ernst	University of Pittsburgh Endocrine Society	1970-74
Kostyo, Jack L.	University of Michigan American Physiological Society	1983-86
Longmire, William	UCLA Society of Surgical Chairmen	1970-71
Lynch, John B.	Vanderbilt University Plastic Surgery Educational Foundation	1980-83
Moody, Frank G. Chair 1986-87	University of Texas/Houston Society of Surgical Chairmen	1982-88
Nurnberger, John	Indiana University American Association of Chairmen of Departments of Psychiatry	1967-69
Oliver, Thomas K. Chair 1978-79	University of Pittsburgh Association of Medical School Pediatric Department Chairmen	1974-80
Pardes, Herbert	Columbia University American Psychiatric Association	1986 -
Petersdorf, Robert G. Chair 1972-73	University of Washington Association of American Physicians	1971-76
Pinn-Wiggins, Vivian W.	Howard University Association of Pathology Chairmen	1988 -
Preston, James B.	SUNY Upstate Association of Chairmen of Departments of Physiology	1977-80
Rhoads, Jonathan Chair 1968-69	University of Pennsylvania Society of Surgical Chairmen	1967-72

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Sacks, Joel	University of Cincinnati American Academy of Ophthalmology	1988 -
Swan, Roy C.	Cornell University Association of Anatomy Chairmen	1976-77
Thier, Samuel O.	Yale University American Federation for Clinical Research	1976-79
Tosteson, Daniel C. Chair 1969-70	Duke University Association of Chairmen of Departments of Physiology	1967-70
Warren, James Chair 1970-71	Ohio State University Association of Professors of Medicine	1968-71
Webster, Leslie T., Jr.	Case Western Reserve University Association for Medical School Pharmacology	1973-77
Wedgwood, Ralph	University of Washington Association of Medical School Pediatric Department Chairmen	1967-69
Weil, William	Michigan State University American Pediatric Society	1969-73
Weldon, Virginia V. Chair 1984-85	Washington University Endocrine Society	1978-86
Welt, Louis	University of North Carolina Association of American Physicians	1970-72
Wilson, Frank C. Chair 1982-83	University of North Carolina American Academy of Orthopaedic Surgeons	1977-84
Yatsu, Frank M.	University of Texas/Houston American Neurological Association	1984-87
Young, Frank E.	University of Rochester Association of Medical School Microbiology Chairmen	1977-79

# The Ad Hoc Group For Medical Research Funding

## FY 1990 RECOMMENDATIONS

For NIH:

<u>FY 1989 Estimate</u>	<u>FY 1990 Current Services</u>	<u>FY 1990 Ad Hoc Group Recommendation</u>
\$7.101 billion	\$7.958 billion	\$8.416 billion

The recommendation would support approximately 6,420 competing research project grants in FY 1990 -- allowing NIH to fund one out of three approved applications. The total number of research project grants would be increased by approximately 1,000. The recommendation assumes full funding for both competing and noncompeting grants.

The Ad Hoc Group recommendation assumes 5.6 percent for inflation. This is the level of increase projected by the Department of Commerce for the Biomedical Research and Development Index.

Funding for research centers, including the GCRC's, would be increased by 8 percent over FY 1989, to provide a small increase over inflation. The number of research career awards would be increased by 250. Other research mechanisms, including the BRSG program, would be increased by 5.6 percent.

The number of research training positions under the National Research Service Award (NRSA) program would be 11,800 -- a 5 percent increase over the number funded in FY 1988, before the stipend increase.

An additional \$50 million is added for unfunded clinical trials. The National Library of Medicine would get \$2 million above inflation for biotechnology.

For ADAMHA:

<u>FY 1989 Estimate</u>	<u>FY 1990 Current Services</u>	<u>FY 1990 Ad Hoc Group Recommendation</u>
\$706 million	\$793 million	\$933 million

This recommendation would support 964 competing research project grants, allowing ADAMHA to fund one out of three approved applications.

The number of research centers would increase from 73 to 90. The number of research career awards would increase by approximately 100.

The number of research training positions would increase from 1,256 to 2,422.

Funding for small instrument grants -- a new initiative in FY 1989 -- would increase from 40 awards at \$51,000 per grant to 113 awards at \$53,000 per grant.

**Construction:**

The above figures do not include construction. NIH had approximately \$38.5 million for intramural construction and \$7.7 million for extramural construction in FY 1989. The current services budget provided by NIH included \$127 million for intramural and \$7.7 for extramural facilities.

The Ad Hoc Group is recommending an additional \$427 million for both intramural and extramural facilities. This includes \$250 million for a combined NIH and ADAMHA program for new extramural construction program, which is not currently authorized and is not contained in either the FY 1989 or the FY 1990 current services, \$50 million for renovation of extramural facilities, and \$127 million for intramural construction. The intramural construction would include Building 49, the child health/neurosciences building, which would also house part of the NIMH intramural neurosciences program.



**CAS PLENARY SESSION**  
**Thursday, March 16, 1989**

**SECTION B**

**COUNCIL OF ACADEMIC SOCIETIES  
COUNCIL PLENARY FORUM  
Oleander Ballroom  
Sonesta Village Hotel  
Thursday, March 16, 1989**

- 8:00 a.m. Continental Breakfast - Preassembly area
- 8:30 a.m. CAS Chairman's Address  
"Status Report: Spring 1989"  
Ernst R. Jaffe', M.D.
- 9:00 a.m. Report on the Institute of Medicine Study  
Itzhak Jacoby, Ph.D.
- 9:15 a.m. "Closing the Gap Between Medical Education  
and Medical Practice"  
Donald Light, Ph.D.
- 9:45 a.m. Charges to the Discussion Groups
- "Is the triple threat academician obsolete?"  
Ernst R. Jaffe', M.D.  
Thomas C. King, M.D.
- "How do we recruit future faculty?"  
Myron Genel, M.D.  
Joe Dan Coulter, Ph.D.
- "How should academic units in medical schools be organized?"  
Douglas E. Kelly, Ph.D.  
Wilton Bunch, M.D., Ph.D.  
Lewis Siegel, Ph.D.
- 10:30 - 11:15 Discussion Groups  
Triple-Threat Academician to Orchid Room  
Recruit Future Faculty to Azalea Room  
Organize Academic Units to Oleander Ballroom
- 11:15 - 11:30 Coffee Break
- 11:30 - 12:30 Discussion Groups
- AFTERNOON FREE
- 6:00 p.m. Discussion Group Reports - Oleander A  
7:00 p.m. Reception - Pool/Veranda Area  
8:00 p.m. Dinner - Oleander Ballroom

**CAS PLENARY SESSION**  
Thursday, March 16, 1989

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- o "Structure and Ideology in Medical Education: An Analysis of  
Resistance to Change," by Samuel W. Bloom..... 57
- o "The Future of Subspecialty Training in Pediatrics," by  
Michael S. Kappy..... 70
- o "Prescription for Medical Education," by David E. Rogers..... 74

Is the Triple-Threat Academician Obsolete?  
Orchid Room

Lewis Aronow  
Bronwyn Bateman  
A. O. Berg  
Hal Bingham  
Thornton Bryan  
Rita Charon  
Frank Davidoff  
William Drucker  
Burton Epstein  
Paul Friedman  
Donald Gann  
George Ginsberg  
Armando Giuliano  
Glenn Hamilton  
John Hanks  
David Herndon  
Solomon Hershey  
Aubrey Hough  
Harry Jacob  
Ernst Jaffe'  
Thomas King  
Elizabeth Martin  
Frank Moody  
Arthur Prange  
Louis Rittelmeyer  
Joel Sacks  
Elizabeth Short  
Stefan Stein  
Karin Wetmore

**How Do We Recruit Future Faculty?**  
Azalea Room

Craighead Alexander  
Rosalie Burns  
Lanny Close  
William Easterling  
John Farrar  
Myron Genel  
Arthur Grant  
Everette James  
Richard Levy  
Thomas Malone  
George Pappas  
David Reines  
Sanford Schwartz  
Steven Shelov  
Norman Snow  
Larry Solomonson  
Richard Weinshilboum  
Jerry Wiener  
Robert Yates

**How Should Academic Units in Medical Schools be Organized?**  
Oleander Ballroom

Warren Adkins  
Milton Alper  
DeWitt Baldwin  
Kenneth Berns  
Mordecai Blaustein  
Wilton Bunch  
David Cohen  
Ed Crocker  
Dale Dauphinee  
K. E. Ebner  
Robert Epstein  
Harold Fallon  
Dorothea Glass  
Robert Greer  
Lee Harker  
Irwin Hassenfeld  
George Hedge  
Gwendolyn Hogan  
Gordon Kaye  
Douglas Kelly  
Louis Kettel  
Douglas Knab  
Robert Kohut  
Philip Larson  
Donald Light  
Roger Markwald  
Harry Mayhew  
David McLeod  
Herbert Pardes  
Vivian Pinn-Wiggins  
Judson Randolph  
Carolyn Robinowitz  
Beverley Rowley  
Lewis Siegel  
Jerome Sutin  
Kat Turner  
Eleanor Wallace  
W. J. Whelan

**BACKGROUND AND DISCUSSION QUESTIONS FOR SPRING MEETING OF  
COUNCIL OF ACADEMIC SOCIETIES, MARCH 16, 1989, ORLANDO, FLORIDA  
"IS THE TRIPLE THREAT ACADEMICIAN OBSOLETE?"**

DEFINITION: A medical school faculty member who teaches students formally (by lecture, small group discussion, as a preceptor, in a laboratory and/or on the wards and clinics of hospitals), carries out biomedical research (usually with extramural grant support), and takes care of patients or, in the case of the non-M.D., may have a formal relationship with private industry as consultant or in a collaborative relationship (the Ph.D.'s "private practice"). When the three-legged stool becomes shaky, may add the fourth leg of administration.

The post World War II era saw the explosive expansion of knowledge in the biomedical sciences, the number of medical schools (80 in 1945, 127 by 1982), and the number of full-time faculty (11,224 (64% clinical sciences) in 1960, 63,312 (77% clinical sciences) in 1986). How and why did this happen?

"The assimilation of medical education into the universities drew academic medicine away from private practice. During the nineteenth century, the medical schools had been organizations of the dominant practitioners in the community. In the twentieth century, academic and private physicians began to diverge and represent distinctive interests and values. A pivotal step in the differentiation of the two groups was the creation of the first full-time academic positions in clinical medicine (in the 1920's)." (1)

"The infusion of money into research and training programs created new opportunities in--and for--medical schools...Medical schools became sprawling complex organizations that now saw their missions as three-fold: research, education, and patient care (usually in that order). Full-time faculty increased 51% between 1940-41 and 1949-50...and during the next decade, full-time positions doubled nationally...This expansion radically changed academic medicine. In the 1920's and 1930's, promotions in medical schools were slow and uncertain...security was rarely achieved before age forty...The U.S. Congress changed all that. NIH research grants helped to build new research centers...and training grants provided stipends for an enlarged corps of investigators...The growth of full-time faculty in clinical as well as basic science departments meant the displacement of local physicians who had served as part-time instructors...Displacement brought resentment and recriminations."(2)

This evolutionary process led to the following typical description.

"The average faculty member had to adapt to a new way of life. Instead of working in the laboratory as an individual, he became the manager of a research team consisting of more junior faculty members, postdoctoral fellows, technicians, and secretaries. Skill in composing research proposals often determined his recognition and advancement. He was on a treadmill, constantly concerned over his current grant, and over the preparation of an equally inspired application for renewal when it expired. His loyalty to the school tended to diminish as he became dependent on outside sources for support of his research, and often for at least a portion of his salary." (3)



Now, extramural research support has become increasingly difficult to obtain, especially for the clinically active physician, and non-governmental sources cannot make up the shortfall and often are not viewed as desirable.

Because of these developments and the enormous technical complexity of modern biomedical research, the triple threat academician, while not obsolete, appears to many to be an endangered species and to be on life support systems.

- 1) Should the plug be pulled, or should transfusions and transplants be considered?
- 2) Do we need triple threat academic physicians? Note the AAMC's strategic goals: #2, To attract the most talented and broadly representative persons into medicine, and #4, To promote a community of interest in academic medicine.
- 3) If so, how many triple threat academicians does the U.S. need? Where do they come from e.g. socioeconomic, family, undergraduate, etc., backgrounds?
- 4) How should academic medical careers be financed? Loans with forgiveness if pursue careers, buy-out provisions if fail?
- 5) How should academicians be paid? Stable university funds with or without tenure, clear obligation of Federal and State governments to pay full direct and indirect costs of research.

- 6) Can high school, college, medical students be steered into becoming triple threat academicians?
  
- 7) Should there be a formal academic medicine track; in college; in medical school; in graduate training programs?
  
- 8) Factors which may have positive or negative impacts, to various degrees, on career choices:
  - a. Need for strict accountability for time spent on research, seeing patients, teaching students?
  
  - b. Competition for academic advancement?
  
  - c. Increasing number of women in medicine?
  
  - d. Need and desire to encourage and attract minorities?
  
  - e. Educational indebtedness, pay back provisions?
  
  - f. "Conflict of priorities," i.e., pressure to teach, do research, see patients or consult with industry?
  
  - g. Constraints of aging research infrastructure?
  
  - h. Constraints of research, teaching space availability?

- i. Well publicized, dramatic instances of fraud and scientific misconduct?
- j. Prohibition of certain types of research, e.g., with fetal tissue, genetic engineering?
- k. Harassment over use of live animals in research?

- (1) Starr, P.: The Social Transformation of American Medicine, Basic Books, Inc., New York, 1982, p. 122.
- (2) Ibid, pp. 352-353.
- (3) Lippard, V.W.: A Half-Century of American Medical Education: 1920-1970, Josiah Macy, Jr., Foundation, New York, 1974, p. 78.

COUNCIL OF ACADEMIC SOCIETIES

SPRING MEETING

MARCH 15-17, 1989

WORKSHOP ON RECRUITMENT AND DEVELOPMENT OF FACULTY

Of late there has been much criticism of the performance of medical school faculty. We are accused of being too heavily vested in research, devoting far too less time and energies to teaching and providing less than adequate role models in the bargain. An unfair and inaccurate characterization, perhaps, but hardly one which is likely to inspire the next generation of academic teachers. Assuredly, efforts must be made to improve the teaching performance of medical school faculties, as well as to enhance the course of instruction. Presuming that we will retain a system closely resembling the current mix of basic and applied (clinical) research, patient care and teaching, where will the next generation of medical school faculty come from? How can they be identified, properly trained and nurtured early in their careers? This workshop will seek to address these questions, especially in the "Light" of present day debate. Specific questions to be addressed include:

1. How can careers in academic medicine/teaching be made more attractive to medical students and to graduate students in the biological sciences?
2. Will increasing levels of indebtedness discourage students from seeking careers in academic medicine? If so, can loan forgiveness programs be developed to assist in faculty recruitment?

3. How can recruitment of potential faculty from minority groups and women be improved? What can be done to improve opportunities for advancement? To provide adequate role models?
4. Are current training programs adequate for development of future medical school faculty members? Is there a common pool of knowledge which should be required by all trainees, irrespective of discipline, such as elements of scientific design and methodology, ethical practices in scientific research and publication and development of more effective teaching techniques?
5. What is the probable impact of changed mandatory retirement? Are there adequate numbers in the development pipeline to replace the large group of faculty who will retire in the next two decades?
6. When we "protect" young faculty members, what are we protecting them from? What are the differential responsibilities of faculty at various stages of their careers?
7. Are there more effective ways in which part-time clinical and adjunct faculty can be utilized? What is the role for utilization of practitioners in ambulatory teaching? What about geographic full-time arrangements?

## HOW SHOULD ACADEMIC UNITS IN MEDICAL SCHOOLS BE ORGANIZED?

Douglas E. Kelly, Ph.D.

Wilton Bunch, M.D., Ph.D.

Lewis Siegel, Ph.D.

For many years, the vast majority of medical schools have been organized around what are now generally regarded as the "traditional" departments of clinical and basic sciences. The enduring justification for this organization lies largely with respect to the maintenance of a "traditional" curricular schedule; two years emphasizing the half-dozen or so "core" basic sciences, and two years devoted mainly to sequential rotation through clerkships in a similar number of major medical specialities. The pattern has varied only when particularly strong individuals and/or programs emerged on a local scene to require or emphasize unorthodox segments, or when major curricular redesign merged courses across disciplinary lines.

Recent years have witnessed increasing pressure to change the traditional design, and not a few reorganizations, some radical, have taken place. New clinical specialities have gained prominence deserving of departmental status: e.g., human genetics, oncology, nuclear medicine, family medicine. Some of these result from new levels of insight or technical capability. Others are born from emerging social needs. Change in basic science organization began with recognition of human behavior as a fundamental element. But, more recently, the driving force has been the explosion of new information, the majority coming from cellular and molecular levels of organization. Basic scientists in all six or seven disciplines find themselves using the same research techniques, asking very similar questions, and training their graduate students accordingly. Here, "new" organizational schemes usually have an interdisciplinary basis: e.g., neurobiology, cell biology, molecular

biology, structural biology, etc. Typically, basic science departments struggle to embrace new research interactions and graduate program designs while teaching a fairly traditional, but increasingly crowded medical curriculum.

Perhaps an equally, if not more, persuasive driving force behind reorganization has been the availability of funds prescribing particular approaches to research or dedicated to the understanding and alleviation of specific diseases or social concerns.

Many new organization schemes are being suggested, and several are in place. In most instances, their birth has not been uncomplicated. Aside from scientific or practical justification, serious issues of faculty morale, implications for tenure, durability, and interaction with other university units are involved. Making a fundamental change is not small undertaking.

Dr. Lewis Siegal, Professor of Biochemistry at Duke University, will describe the process by which one medical school faced these issues and has embarked upon what it believes to be a satisfactory solution.

Dr. Wilton Bunch, Dean of the College of Medicine at the University of South Florida will draw upon his varied experience at several institutions to focus on reorganizational needs at the clinical level.

Questions to be entertained include:

1. What patterns of reorganization seem to be emerging in the basic sciences? . . . In the clinical sciences?
2. What are advantages and disadvantages of reorganizing to favor the welfare of research activities and education of graduate students and postdoctoral fellows?
3. Is the organization that seems to provide financial security the best for the educational continuum and/or faculty morale?

4. Is it practical for faculty to serve both a departmental organization as well as a "center"- or "institute"-oriented superstructure?

5. To what extent does technology transfer promote unorthodox patterns of organization?

Discussion will follow.



**CAS BUSINESS MEETING**  
**Friday, March 17, 1989**

**SECTION C**

AGENDA

COUNCIL OF ACADEMIC SOCIETIES  
BUSINESS MEETING

March 17, 1989  
Oleander Ballroom  
Sonesta Village Hotel  
Orlando, Florida

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- II. President's Report  
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- III. Action and Discussion Items
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- D. Clinical Pharmacology Education: A Paradigm for Basic Sciences-  
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- G. Reports from the CAS Administrative Board Working Groups
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- Discontinuities in Medical Education  
Frank G. Moody, M.D.

- H. AAMC Strategic Plan.....handout  
John F. Sherman, Ph.D.
- I. Legislative Update.....handout  
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- J. AAMC Task Force on Physician Supply.....handout
- K. AAMC Framework Document for Institutional Policies and Procedures  
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- M. Declining Autopsy Rates  
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- N. Medicare Proposed Regulations on Payment for Physician Services  
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**MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING**

November 14, 1988  
Chicago Marriott Downtown  
Chicago, Illinois

**II. PRESIDENT'S REPORT**

Robert G. Petersdorf, M.D.

Dr. Petersdorf acknowledged Dr. Malone's recent appointment as the first Vice President for Biomedical Research at the AAMC, and stated that with the appointment of Herbert Nickens, M.D., as Vice President for Minority Affairs, Disease Prevention and Health Promotion, effective December 1, the Association's Executive Staff recruitment will be complete. The strategic plan for the AAMC, which has been a focus of the Executive Staff in recent months, includes a new mission statement approved by the Executive Council in June, with a set of seven strategic goals. The strategic plan and goals will be the subject of the Officers' Retreat in December.

Dr. Petersdorf stated that a high priority of his has been to attract outside support for program activities, and that effort has become successful, with awards to the AAMC from the Macy and Robert Wood Johnson Foundations for expanded activities in minority participation in medical education. These initiatives will be directed by Dr. Nickens. Another major grant was received from the Charles E. Culpeper Foundation to support an in depth examination of curricular changes being undertaken at the medical schools. This is the first major curriculum study since the GPEP report and will be directed by Lou Kettel, M.D., Associate Vice President for Academic Affairs.

Academic Medicine, the new journal, will be appearing in January, and will be wide-ranging in content and scope. Although peer-reviewed articles will remain at the heart of the journal, its editorial content will expand to include invited policy articles as well as several regular columns.

Jack Graettinger, President of the National Resident Matching Program, has announced his retirement, and the NRMP Board has asked AAMC to become the manager and administrator of the NRMP. At present, NRMP offices will remain in Evanston, Illinois, and the current governing Board will continue its functions.

First year enrollment is up 42 places from last year. At 20 weeks into the application cycle for the 1989 entering class, a less than 3% decline in the number of applicants compared to this point in last year's process heralds a sharp slowing of the declining applicant pool which has been of much concern to the medical education community.

The AAMC Task Force on AIDS and the Academic Medical Center will complete its work this year. Its report on policy guidelines for addressing HIV infection in the academic medical community was distributed just before the Annual Meeting, and was praised by Surgeon General Koop in his keynote address during the Sunday Plenary Session. The MCAT Review Committee and the Task Force on Physician Supply continue their deliberations. A new committee on the effect of the nursing shortage on teaching hospital activities will be formed in the coming months, and the AAMC will publish new documents on the ethical behavior of medical researchers and institutional policies to deal with misconduct in science, trends in hospital profits with emphasis on recent teaching hospital data, and the nature of research awards. The Association will consider the Hsiao study and some of the issues it raises.

I. CHAIRMAN'S REPORT  
Douglas E. Kelly, Ph.D.

Dr. Kelly welcomed new CAS Representatives, and introduced the Administrative Board members, Dr. Malone, and Dr. Nickens. He reported on the successful initiation of the Liaison Project, in which 8 CAS societies were assigned to each Administrative Board member for the purpose of establishing and maintaining closer communications. Dr. Kelly encouraged societies to appoint their CAS Representatives for sufficiently long terms to become involved with and active in the CAS and AAMC. Terms should be 3 to 4 years at a minimum, and should be staggered between the two representatives to insure continuity.

III. VICE PRESIDENT'S REPORT  
Thomas E. Malone, Ph.D.

Dr. Malone gave a brief summary of his background and the organization and staffing of the Division of Biomedical Research. He stated that he hopes to improve the use of the talent found in the CAS. Among the issues covered by the Division are misconduct in science, fetal research, animal welfare, research resources, and support of federal research funding through the Ad Hoc Group for Medical Research, as well as staff support for the Council. Among initiatives that Dr. Malone expressed intentions to pursue are increasing contact with officials of NIH, ADAMHA, FDA and IOM, and producing additional publications in the areas of research manpower, university-industry relationships, research in teaching hospitals, animal welfare, and space management. Dr. Malone mentioned that he has been very involved in the development of the AAMC's strategic planning process, particularly with regard to research issues and the role of the CAS.

IV. ACTION AND DISCUSSION ITEMS

A. Consideration of Minutes

ACTION: The minutes of the 1988 Spring Meeting were approved as submitted.

B. Nominating Committee Report

Ernst R. Jaffe', M.D., presented the slate prepared by the Nominating Committee. For Chair-Elect, the Committee nominated Joe Dan Coulter, Ph.D., Chairman of Anatomy at the University of Iowa and CAS Representative from the Society for Neuroscience. For three-year terms on the Administrative Board, the nominees are Kenneth I. Berns, M.D., Ph.D., Cornell University Medical College, representing the Association of Medical School Microbiology Chairmen; Thornton Bryan, M.D., University of Alabama Family Practice Center at Huntsville, representing the Association of Departments of Family Medicine; and Glenn C. Hamilton, M.D., Wright State University, representing the Society of Teachers of Emergency Medicine. The Nominating Committee also nominated S. Craighead Alexander, M.D., as a candidate for a three-year term as At-Large Representative from the CAS to the AAMC Executive Council.

ACTION. The slate was approved as submitted.

C. Legislative Update

Richard Knapp, Ph.D.

Dr. Knapp introduced David Moore, former CAS staffer, who is now Assistant Director of Government Relations for the AAMC. The Legislative and Regulatory Update provided an overview of the major issues of the 100th Congress, as well as AAMC activities such as participation in coalitions on the issues of animals in research, the Ad Hoc Group for Medical Research, and support of the Veterans Administration research budget. AAMC representatives testified 15 times before Congress this year on these and other issues.

Among the issues which the 101st Congress, entering in January 1989, is expected to address are changes in taxation, especially of unrelated business income; Medicare/Medicaid; health facilities research; fraud and misconduct in science and conflict of interest; Veterans Administration budget, particularly in medical care needs; physician recertification; licensure of foreign medical graduates; student loan defaults and deferments; the use of animals in research; abortion; the use of fetal tissue in research and fetal research; long-term care; and the NIH budget. Dr. Knapp noted that although the NIH budget increased \$480 million in FY89, the perception in the medical research community is that it is eroding. He reasoned that this is partly due to the increased length of awarded grants, so that fewer dollars are available for competing renewals. This year alone, competing renewals had \$78 million less than in the previous year. Since stipend levels are higher on NRSA awards, there will also be a smaller number of trainees supported.

Senator Weicker's election loss will mean a major change in relationships with the Senate Appropriations Subcommittee on Labor and Health and Human Services, but there will be no change on the House side. Senator James Sasser (D-TN) and Rep. Leon Panetta (D-CA) will be the new chairs of the respective Budget Committees, and there will be 17 changes in the membership of the Budget Committees.

D. Reports from the CAS Administrative Board Committees

1. Dr. Kelly reported for the Committee considering development of an Educator/Researcher Award. The purpose of such an award would be support, recognition and reward for mid-career faculty development for proven educators. The Committee's current plan is to provide \$50,000 per year for 3 to 4 years with few restrictions and maximum flexibility. Awards would be institution-based, with an award given at each medical school. It is expected that either clinical or basic scientists at the Associate Professor level, spending about 50% of their effort on education, would be eligible. Foundation support will be pursued.

2. Dr. Coulter reported for the Subcommittee on Faculty Development and Evaluation. The perception exists that there is an almost total lack of integrated faculty development at most institutions. Salary does not appear to be linked to performance, although the difficulty in evaluating teaching is acknowledged. Dr. Coulter believes that to tackle this subject effectively will require a major initiative by the AAMC, and he elicited opinions from the CAS about the amount of enthusiasm for such an initiative, which was substantial. CAS Representatives considered faculty development and evaluation central to the mission of the Council. Among the needs suggested for such a project were how to retrain older faculty and develop younger faculty; development of a set of guidelines for faculty evaluation with flexibility for specialty and institutional differences; objectives with which promotion decisions can be made; consideration of the role of Ph.D.s in clinical departments; and ways to let faculty, especially younger faculty, know what is expected of them by the institution or department.

3. Frank G. Moody, M.D. reported for the Committee considering Discontinuities in Medical Education. In consideration of the Ebert-Ginzburg monograph, the Committee favored combining the last two years of medical school with the first two years of graduate education, but disagreed with the concept of a core teaching faculty, with faculty not designated as such pursuing other activities. It was their strong belief that all medical school faculty should teach.

E. Task Force on Women, Minorities and the Handicapped in Science  
Jo Anne Brasel, M.D.

Dr. Brasel is the only current academic faculty member serving on this Task Force. She reported that the deliberations of the Task Force relate very closely to the message in Mayor Cisneros's plenary speech about broadening the base of people in science and technology. The changes in demographics, both in aging and ethnic makeup of the population, will work dramatic changes in this country in the next 15 years. Dr. Brasel urged the CAS to act upon recruitment of underrepresented minorities. This Task Force will continue for one more year, during which members are charged to get the message out to the scientific community, the public and the government. Copies of the full report are available from Dr. Brasel.

K. New Business

Myron Genel, M.D. asked the Council to consider carefully the implications of the upcoming merger of the Division of Research Resources and the Division of Research Services within the National Institutes of Health. There is a short amount of time in which to respond to the changes, as outlined in an AAMC informational memorandum mailed shortly before the Annual Meeting, but societies were strongly urged to write NIH with comments. Dr. Malone stated that he or Dr. Sherman may testify before the NIH Committee considering the merger, but comments from the community are essential to the NIH's deliberations.

F. Declining Autopsy Rates

Vivian W. Pinn-Wiggins, M.D.

Dr. Pinn-Wiggins briefly presented the concerns of the pathologists about the declining autopsy rates, paralleling the full report she gave to the CAS Administrative Board in September. An important factor contributing to the decline is that modern diagnostic tools cause clinicians to believe that they have complete knowledge of the patient's cause of death, but recent studies show that traditional rates of discrepancy between pre- and postmortem diagnoses continue. Other major reasons for the decline are that lack of exposure to autopsies for medical students makes them less comfortable with and less likely to request autopsies when they become housestaff, a lack of interest on the part of pathologists, and fear of malpractice suits. Studies have suggested, however, that autopsies may lower the number of malpractice awards and reduce the risk of financial loss from malpractice suits. Dr. Malone reported that Dr. Petersdorf brought this issue to the attention of the Council for Medical Affairs, and that the AAMC Executive Council will consider it at their February 1989 meeting.

J. 1989 Spring Meeting

Dr. Jaffe' invited all Representatives to attend the CAS Spring Meeting, which will be held March 15-17, 1989 in Orlando, Florida. The meeting theme will be "American Medical Faculty in the 21st Century: Challenges and Responsibilities," and discussion groups will consider whether the triple-threat academician is obsolete, how future faculty will be recruited, and how academic units in medical schools should be organized. An orientation session for new CAS Representatives will be an important addition to the meeting this year, and all Representatives, whether new or old, were urged by Dr. Jaffe' to attend the orientation.

G. Declining Applicant Pool

August G. Swanson, M.D.

Dr. Swanson stated that since 1984, applications have decreased 26%. The 1988 pool is 5% less than 1987, and it appears that 1989 applications will be stable or very slightly increased. It is also notable that women and underrepresented minorities are applying in substantially greater numbers. Application trends differ widely by region, with the western states considerably more competitive



for medical school admission than other areas of the country. The least competition appears in the midwest. 60% of this year's applicant pool was admitted, compared to 46% in 1981. MCAT scores and GPAs of matriculants are down marginally. The lack of real change in the matriculant pool has made it less competitive to enter medical school, but there is no data indicating that the students being admitted are less academically able, and there is data showing that the students who are applying are doing so for more altruistic reasons.

H. Improvements in the Transition from Medical School to Residency

August G. Swanson, M.D.

Dr. Swanson called the attention of the group to the experiences of 1988 medical school graduates in obtaining residencies which are detailed in the series of charts beginning on page 27 of the agenda book. The trends are clearly in the direction hoped for by the AAMC Committee on the Transition from Medical School to Residency. Program directors are shifting their schedules to later in the school year and NBME scores are becoming less important in the selection process, but audition electives are still required in the more competitive specialties. There is a slight decrease in the number of students being requested to make a commitment to residencies prior to the NRMP match, with the psychiatrists having the most dramatic reduction. For the last three years, Dr. Swanson has led a meeting with the program directors to discuss the issues and problems around changes in the transition, and as a result of these meetings, a guideline for writing the deans' letter has been issued.

I. Academic Medicine

Dr. Kelly introduced Editor Addeane Caelleigh, who described major changes in the journal, including the graphic format and addition of invited formal essays. Peer reviewed articles will continue and will supply 1/3 to 1/2 of the contents, with more stringent peer review standards being implemented. CAS Representatives were encouraged to submit essays for publication, particularly in cross-disciplinary areas, policy-making areas, and problem-solving areas that affect the whole academic medicine community.

V. Awards

Dr. Kelly recognized Elizabeth M. Short, M.D. for her five years at the AAMC, working with the CAS and as Deputy Director for Biomedical Research. Although Dr. Short has left AAMC for the Veterans Administration, she will continue to be part of the Council as CAS Representative from the American Society for Human Genetics.

Dr. Kelly turned the leadership of the CAS over to Dr. Jaffe', who then presented Dr. Kelly with the traditional Captain's Bell.

COUNCIL OF ACADEMIC SOCIETIES  
Annual Meeting Registration  
November 13-14, 1988  
Chicago, Illinois

<u>Society</u>	<u>Representative</u>
Academy of Clinical Laboratory Physicians and Scientists	James Winkelman
Ambulatory Pediatric Association	Jay Berkelhamer
American Academy of Allergy and Immunology	Paul VanArsdel
American Academy of Neurology	Rosalie A. Burns
American Academy of Ophthalmology	Joel Sacks Bronwyn Bateman
American Academy of Orthopaedic Surgeons	James H. Herndon
American Academy of Physical Medicine and Rehabilitation	James Demopoulos
American Association for the Study of Liver Diseases	
American Association for the Surgery of Trauma	William R. Drucker
American Association for Thoracic Surgery	Thomas C. King
American Association of Anatomists	Douglas E. Kelly Robert D. Yates
American Association of Chairmen of Departments of Psychiatry	Jerry Wiener
American Association of Chairmen of Plastic Surgery	Robert L. Ruberg
American Association of Directors of Psychiatric Residency Training	Stefan Stein George Ginsberg
American Association of Neurological Surgeons	
American Association of Pathologists	

American Association of Plastic Surgeons	
American College of Neuropsychopharmacology	Arnold Friedhoff
American College of Obstetricians and Gynecologists	William E. Easterling, Jr.
American College of Physicians	
American College of Psychiatrists	Peter Regan Robert L. Williams
American Federation for Clinical Research	J. Sanford Schwartz
American Gastroenterological Association	John T. Farrar
American Geriatrics Society	Knight Steel
American Neurological Association	
American Orthopaedic Association	
American Pediatric Society	Myron Genel
American Physiological Society	George Hedge
American Psychiatric Association	Herbert Pardes Daniel X. Freedman
American Society for Biochemistry and Molecular Biology	Kurt Ebner
American Society for Cell Biology	Barbara McLaughlin
American Society for Clinical Investigation	
American Society for Clinical Nutrition	Charles Halsted
American Society for Clinical Pharmacology and Therapeutics	David Nierenberg
American Society for Pharmacology and Experimental Therapeutics	Lewis Aronow
American Society of Hematology	Harry Jacob Ernst R. Jaffe
American Society of Human Genetics	Elizabeth M. Short

American Surgical Association	
Association for Academic Psychiatry	Louis Rittelmeyer Carolyn B. Robinowitz
Association for Academic Surgery	Martha McDaniel
Association for Medical School Pharmacology	Raymond L. Woosley Edmund G. Anderson
Association for the Behavioral Sciences and Medical Education	Beverley D. Rowley
Association for Surgical Education	Norman Snow
Association of Academic Departments of Otolaryngology	Warren Y. Adkins Robert I. Kohut
Association of Academic Physiatrists	Judy Suthin
Association of American Physicians	
Association of Anatomy Chairmen	Gordon Kaye Robert O. Kelley
Association of Anesthesiology Program Directors	Robert M. Epstein
Association of Chairmen of Departments of Physiology	W. F. Ganong Stanley Schultz
Association of Departments of Family Medicine	Thornton Bryan Harry E. Mayhew
Association of Directors of Medical Student Education in Psychiatry	Irwin Hassenfeld John Racy
Association of Medical School Departments of Biochemistry	Richard Schultz
Association of Medical School Microbiology Chairmen	Kenneth Berns
Association of Medical School Pediatric Department Chairmen	Harold Maurer
Association of Orthopaedic Chairmen	Gerald Laros

Association of Pathology Chairmen	Aubrey Hough Vivian Pinn-Wiggins
Association of Pediatric Program Directors	Leah Reimann
Association of Professors of Dermatology	
Association of Professors of Gynecology and Obstetrics	
Association of Professors of Medicine	
Association of Program Directors in Internal Medicine	Marvin Forland
Association of Teachers of Preventive Medicine	
Association of University Anesthetists	Milton Alper C. Philip Larson, Jr.
Association of University Professors of Neurology	Mark L. Dyken
Association of University Professors of Ophthalmology	Claude Cowan
Association of University Radiologists	A. Everette James, Jr.
Central Society for Clinical Research	John Phair
Child Neurology Society	Gwendolyn Hogan
Endocrine Society	JoAnne Brasel Virginia Weldon
Plastic Surgery Educational Foundation	Robert Ruberg
Plastic Surgery Research Council	Nancy McKee
Society for Health and Human Values	
Society for Neuroscience	David H. Cohen Joe Dan Coulter
Society for Pediatric Research	Harvey J. Cohen
Society for Surgery of the Alimentary Tract	Henry A. Pitt

Society of Academic Anesthesia Chairmen	Burton Epstein S. Craighead Alexander
Society of Chairmen of Academic Radiology Departments	
Society of Critical Care Medicine	S. G. Hershey H. David Reines
Society of Gynecologic Investigation	Anne Colston Wentz
Society of Surgical Chairmen	Frank Moody
Society of Teachers of Emergency Medicine	Richard Nowak Glenn C. Hamilton
Society of Teachers of Family Medicine	Alfred O. Berg
Society of University Otolaryngologists	Lanny Garth Close Lee A. Harker
Society of University Surgeons	
Society of University Urologists	David G. McLeod
Surgical Infection Society	David N. Herndon Arthur Baue
Thoracic Surgery Directors Association	
University Association for Emergency Medicine	Richard C. Levy
TOTAL: 70 Societies	92 Representatives

MEMBERSHIP APPLICATION

COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

ATTENTION: Jane Donovan

NAME OF SOCIETY: American College of CLinical Pharmacology

MAILING ADDRESS: 175 Strafford Avenue, Suite 1  
Wayne, PA 19087

PURPOSE: The College was founded in order to promote the science of clinical pharmacology in all its phases and to engage in other appropriate educational efforts in the public interest.

MEMBERSHIP CRITERIA: FELLOW: Individuals who have earned the doctoral degree in any of the health care professions or in any one of the biomedical/pharmaceutical sciences and in addition, shall have at least 3 years of postdoctoral training or equivalent experience in either the basic biomedical/pharmaceutical sciences or a clinical health care specialty and show evidence of meritorious work which is (continued on reverse side)

NUMBER OF MEMBERS: 832

NUMBER OF FACULTY MEMBERS: 80%

DATE ORGANIZED: September 11, 1969

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

1. Constitution and Bylaws 10/17/85
2. Program and Minutes of Annual Meeting 17th Annual Mtg. Oct. 31-Nov. 3, 1988  
16th Annual Meeting, Oct. 14-17, 1987
3. Copy of IRS Approval under Sections 501(c)(3) and 509(a)  
of the Internal Revenue Code 10/29/75

11/10/88  
Date Completed

W.F. Chaveas  
Completed by - Signature

William F. Chaveas  
Completed by - Please Print

Executive Director  
Title

FELLOW: (cont'd) acceptable to the Credentials Committee and the Board of Regents. All applications for Fellowship must be supported by two (2) letters of recommendation from Fellows of the College.

MEMBER: Individuals who have earned the doctoral degree in any of the health care professions or in any one of the biomedical/pharmaceutical sciences, or its equivalent. The candidate must submit evidence of a substantial interest in clinical pharmacology to the Credentials Committee.

ASSOC. MEMBER: Individuals who have demonstrated an interest in clinical pharmacology, but who do not otherwise meet the requirements for Fellow or Member status. Associates may be considered by the Credentials Committee for advancement to Member or Fellow status upon presentation of additional qualifications.



MEMBERSHIP APPLICATION

COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

ATTENTION: Jane Donovan

NAME OF SOCIETY: Association of Academic Health Science Library Directors

MAILING ADDRESS: Houston Academy of Medicine - Texas Medical Center Library  
1133 M.D. Anderson Boulevard  
Houston, Texas 77030

PURPOSE: The purposes of this Association are:

- a) to promote, in cooperation with educational institutions, other educational associations, government agencies, and other non-profit organizations, the common interests of academic health sciences libraries located in the United States and elsewhere, through publications, research and discussions of problems of mutual interest and concern; and (See Attached)

MEMBERSHIP CRITERIA: Regular Members. Regular members shall be educational institutions (or division, department, or section thereof which is an academic health sciences library) which are either (a) organizations exempt from Federal income taxation under Section 115(a) of the Internal Revenue Code of 1954 or (b) organizations exempt from Federal income tax under Section 501(a) as organizations described in 501(c)(3) which also are not private foundations under Section 509(a)(1), (2), or (3) of said Code (or the corresponding provisions of any future United States Internal Revenue law). (See Attached)

NUMBER OF MEMBERS: 119

NUMBER OF FACULTY MEMBERS: 1,420

DATE ORGANIZED: 1978

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

1. Constitution and Bylaws 10/26/86
2. Program and Minutes of Annual Meeting October 1987
3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code 03/26/80

10/28/88

Date Completed

Nina W. Matheson

Completed by - Signature

Nina W. Matheson

Completed by - Please Print

President  
Title

PURPOSE: (cont'd)

- b) to advance the efficient operation of academic health sciences libraries for the benefit of faculty, students, staff, administrators and practitioners.

MEMBERSHIP CRITERIA: (cont'd)

Associate Members. Associate Members shall be organizations having an interest in the purposes and activities of the Association. Associate Members shall not be eligible to vote and shall not be able to hold office in the Association.

# AMA-Fellowship and Residency Electronic Interactive Database Access (AMA-FREIDA):

## A Computerized Residency Selection Tool

Over the past several years, medical educators and students have been expressing increasing concern about the selection process for graduate medical education programs. The senior year of medical school is a period of intense pressure when medical students must choose a specialty, select a graduate program, and, in some cases, rehearse an internship.<sup>1</sup> Residents who have experienced that process have stated that they did not have enough information to make an informed choice.<sup>1,2</sup>

Students seek information about graduate medical education programs from a variety of sources. However, 52% of residents in one study said they did not have available the information they needed to make a decision about a graduate medical education program.<sup>4</sup> One study found the *Directory of Graduate Medical Education Programs* to be the single most important source of information.<sup>3</sup> Another study found that residents consider published information to be the most important source, particularly program brochures.<sup>4</sup>

Respondents to one study suggested several types of information they would like to have available to them during the selection process, including information about call schedules and duty time of the residents.<sup>3</sup> Residents in two studies indicated that geographic location was the most important factor in selecting a graduate medical education program.<sup>3,5</sup> Other considerations for selecting a program included such concerns as whether the program was affiliated with a university.<sup>3</sup> One author concluded that quality-of-life issues may be playing a more significant role in the medical student's choice of a residency than the educational features of the program.<sup>2</sup>

Frustrated with the graduate medical education program selection process, members of the Resident Physicians Section of the American Medical Association (AMA) petitioned the AMA House of Delegates to institute a computerized information service on graduate medical education programs. The goal of this service was to have adequate information available to students to help in the choice of a graduate medical education program. As a result of the action of the House of Delegates, the AMA-Fellowship and Residency Electronic Interactive Database Access (AMA-FREIDA) system is being developed.

The AMA-FREIDA system will significantly expand the information currently available in the *Directory of Graduate Medical Education Programs*. The developing system will allow information to be available through a computer database. Every graduate medical education program will be asked to provide the information necessary for its listing in the automated directory. Access to the database will be via a twice yearly updated software package available for purchase by medical schools, institutions, graduate medical education programs, and others.

The AMA-FREIDA system will contain approximately 16 data elements for each graduate medical education program, including such information as name, address, and telephone number of the program director; basic demographic information about the residents in the program and the program faculty; call schedule information; research opportunities; features of the program, such as night float

coverage, stress management programs, career counseling, and part-time or shared positions; and salaries and leave-of-absence policies.

In addition to the program data, there will be approximately 165 data elements on every institution associated with a program. Information on institutions will include basic demographic information about the medical staff; basic demographic information about the patient population and the population of the county in which the institution is located; available institutional resources, such as intensive care units, medical library services, transplant programs, and 24-hour laboratory services; benefits available for residents, such as major medical insurance and life insurance; features of the institution, such as the availability of loan deferment status, on-call quarters, housing allowance, house staff organization, and child care; and the cost of an apartment within walking distance of the institution.

These data will be organized into a user-friendly computer system that will encourage the student to use a series of primary and secondary search criteria to narrow the field of potential program choices. The end result will be a list of programs most appropriate for the user's circumstances.

The goal of the AMA-FREIDA system is to provide, in a uniform format, general data that applies to most residencies and institutions. Students will be encouraged to correspond with programs from which they want further information. To facilitate that communication, the computer program will generate mailing labels for the user's final list of residencies. The benefit for the student will be fewer inquiries and more focused applications. Benefits to program directors will be fewer inquiries from more informed students and applicants who are more committed to seeking a position in the program.

The preliminary design stage for the AMA-FREIDA system was completed in the early spring of 1988. The technical design and implementation phases will begin in the summer of 1988. It is expected that the new computerized data-gathering system will be operational in July 1989. The first version of AMA-FREIDA, the automated *Directory of Graduate Medical Education Programs*, will be available in the spring of 1990.

Questions about the system should be directed to the Office of Medical Education Information Analysis, American Medical Association, 535 N Dearborn St, Chicago, IL 60610.

Beverly Davies Rowley, PhD  
Research Manager  
Office of Medical Education  
Information Analysis  
American Medical Association  
Chicago

1. Weinberg E, Casty F: Results of a survey concerning application for residency training. *J Med Educ* 1987;62:763-765.
2. Sledge WH, Leaf PJ, Sacks MH: Applicants' choice of a residency training program. *Am J Psychiatry* 1987;144:501-503.
3. Bunch WH, Chapman RG, Dvonch VM: The candidate's view of the orthopaedic residency selection process. *J Bone Joint Surg Am* 1986;68:1292-1296.
4. Taggart MP, Wartman SA, Weasen AF: Medical students' access to information in resources for the residency selection process. *J Med Educ* 1988;63:1:38-43.

PROGRAM DATA SCREEN 1 OF 6

\*\*\* BASIC DATA \*\*\*

SPECIALTY NAME XX  
 PROGRAM NAME XX  
 XX  
 PROGRAM NUMBER 999-99-999  
 PROGRAM DIR. XX  
 ADDRESS1 XXXXXXXXXXXXXXXXXXXXXXXX  
 ADDRESS2 XXXXXXXXXXXXXXXXXXXXXXXX  
 ADDRESS3 XXXXXXXXXXXXXXXXXXXXXXXX  
 CITY XXXXXXXXXXXXXXXX  
 STATE XX  
 ZIP CODE 99999-9999

\*\*\* SUMMARY INSTITUTION DATA \*\*\*

SPONSORING INSTITUTION XX  
 XX  
 # OF HOSPITAL FACILITIES FOR REQUIRED ROTATIONS 99 # OF NON-HOSPITAL FACILITIES FOR REQUIRED ROTATIONS 99

(I)Institution Data, (R)Restart, (O)Quit, (F)Display Screen Handling Commands

PROGRAM DATA SCREEN 2 OF 6

\*\*\* PROGRAM COMPOSITION \*\*\*

OVERALL	RESIDENT	FACULTY
ACCREDITED LENGTH OF PROGRAM (YRS) 99	MALE 99.9 FEMALE 99.9	MD/DO FACULTY FULL-TIME(PAID) 9999 PART-TIME(PAID) 9999 VOLUNTARY 9999 FEMALE (%) 99.9 FMG (%) 99.9
# OF TOTAL BUDGETED POSITIONS Y1 99 Y5 99 Y2 99 Y6 99 Y3 99 Y7 99 Y4 99 Y8 99 TOTAL 999	GRADUATES OF OSTEOPATHIC MEDICAL SCHOOLS 99.9 GRADUATES OF FOREIGN MEDICAL SCHOOLS 99.9	NON MD/DO FACULTY FULL-TIME(PAID) 9999 PART-TIME(PAID) 9999 VOLUNTARY 9999 FEMALE (%) 99.9 FOREIGN SCHOOL GRADUATES 99.9
# OF POSITIONS OPEN TO GY-1 99	WHITE (NON HISPANIC) 99.9 BLACK (NON HISPANIC) 99.9 ASIAN OR PACIF ISLANDER 99.9 AM IND OR ALASK NATIVE 99.9 MEXICAN AMERICAN 99.9 PUERTO RICAN 99.9 OTHER HISPANIC 99.9	

(I)Institution Data, (R)Restart, (O)Quit, (F)Display Screen Handling Commands

PROGRAM DATA SCREEN 3 OF 6

\*\*\* WORK ENVIRONMENT \*\*\*

PRIMARY CARE TRACK AVAILABLE XXX AVG NIGHTS ON CALL  
 Y1 999d Y4 999d  
 RECD/FORMAL CONFERENCE/SEMINAR HRS/WEEK PER RESIDENT (Y1) 99.9 Y2 999d Y5 999d  
 Y3 999d Y6 999d  
 MED STUDS WHICH GY-1 RESIDENT RESPONSIBLE 99 2ND LANGUAGE RECOMMENDED XXX  
 MOONLIGHTING ALLOWED XXX FREQUENCY OF PERFORMANCE EVALUATIONS/YR 99

% OF RESIDENTS IN LAST 5 YEARS WHO:  
 HAVE BEEN ELIGIBLE TO SIT FOR SPECIALTY BOARD EXAMS 999.9  
 HAVE PASSED SPECIALTY BOARD EXAMS 999.9  
 HAVE ENTERED SUBSPECIALTY PROGRAMS 999.9

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PROGRAM DATA SCREEN 4 OF 6

\*\*\* WORK ENVIRONMENT \*\*\*

AVG # OF HRS/MO ON DUTY (Y1) 999 # OF 24 HR PERIODS/MO OFF DUTY (Y1) 9  
 RECD TOTAL WEEKS ON DUTY IN NON-HOSPITAL SETTING (LOP) 999 RESEARCH # OF WKS (LOP) XXXX 999  
 MAX # OF CONSECUTIVE HRS PERMITTED ON DUTY (Y1) 999 ELECTIVES # OF WKS (LOP) XXXX 999

\*\* OTHER \*\*

NIGHT FLOAT CALL  
 CROSS CALL COVERAGE  
 REPRESENTATION ON MAJOR DEPARTMENT COMMITTEES  
 REPRESENTATION ON MAJOR HOSPITAL COMMITTEES  
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 WRITT POLICY ON HANDICAP IMPAIRMENT APPLIC TO RESIDENTS  
 WRITT POLICY ON HANDICAP IMPAIRMENT APPLIC TO MED STAFF

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PROGRAM DATA SCREEN 5 OF 6

\*\*\*\*COMPENSATION, BENEFITS, AND OTHER PROGRAM FEATURES\*\*\*\*

***SALARY***		***PROGRAM FEATURES***	
Y1 999.999	Y4 999.999	PART-TIME SHARED POSITIONS	
Y2 999.999	Y5 999.999	COMPUTERIZED LIBRARY SERVICES	
Y3 999.999	Y6 999.999	PERSONAL COMPUTER ACCESS	
		COMPUTERIZED SYST TO DOCUMENT RESID EXPERIENCE	
		PROFESSIONAL MEMBERSHIPS PAID	
		MENTOR/FACULTY ADVISOR	
		CAREER COUNSELING	
		ETHICS CURRICULUM	
		PRACTICE MANAGEMENT SEMINARS	
		STRESS MANAGEMENT PROGRAM(S)	

\*\*\*PAID LIABILITY INSURANCE\*\*\*  
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

\*\*\*LEAVE POLICY\*\*\*

**ANNUAL LEAVE (DAYS)**		**SICK LEAVE (DAYS)**		**OTHER**	
Y1 999	Y4 999	Y1 999	Y4 999	MATERNITY	
Y2 999	Y5 999	Y2 999	Y5 999	PATERNITY	
Y3 999	Y6 999	Y3 999	Y6 999	EDUCAT W/ EXP REIMB	
				EDUCAT W/O EXP REIMB	

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PROGRAM DATA SCREEN 6 OF 6

\*\*\* GENERAL \*\*\*

PROGRAM MATCH # 999999 999999 999999 999999  
 PROGRAM START DATE  
 JULY XXX  
 JANUARY XXX  
 NEGOTIABLE XXX

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AAMC

ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW  
WASHINGTON, DC 20036  
TELEPHONE (202) 828-0400

January 26, 1989

Dear Colleague:

As you are well aware, external and internal influences affecting the nation's academic medical centers have changed substantially in recent years. As a consequence, the elected officers of our Association have initiated two significant efforts to assure the most effective service possible from the AAMC for its members. The first, the establishment of a strategic planning process, is now well under way by the Executive Staff. The second is the subject of this communication.

The Association's Executive Committee has appointed us, recent former Chairs of the Association, as a Committee on Governance and Structure to review in comprehensive fashion the appropriateness of the current organizational characteristics of the AAMC. A copy of the charge to our committee is attached, highlighting the several considerations to which particular attention must be directed.

We write now to solicit your observations or suggestions or those of your associates on these issues to facilitate our efforts. The Committee must proceed promptly with its task in order to formulate its recommendations this spring for consideration by the Administrative Boards and the Executive Council prior to this year's AAMC annual meeting. We would be grateful if you would convey your thoughts to any committee member not later than February 15. If questions arise about the committee's work, please feel free to communicate with any of us or with John F. Sherman, Ph.D., Executive Vice President of the Association, who is acting as staff to our committee.

Thank you for your help with this important matter.

Sincerely yours,

John W. Colloton - Chairman,  
AAMC Governance & Structure Committee  
Director, University of Iowa Hospitals  
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Addressees: Council of Academic Societies  
Council of Deans  
Council of Teaching Hospitals  
Organization of Student Representatives  
Steering Committees - AAMC Groups  
Past Chairs of AAMC Assembly  
Officers and Board of Directors, Association of Academic Health Centers

Attachment

cc: John F. Sherman, Ph.D.



ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW  
WASHINGTON, DC 20036  
TELEPHONE (202) 828-0400

#### CHARGE TO THE COMMITTEE ON GOVERNANCE AND STRUCTURE

In 1965, the Association of American Medical Colleges received the report "Planning for Medical Progress Through Education." The report, known as the Coggeshall Report after its chairman Lowell Coggeshall, a past president of the AAMC, spoke broadly on issues of medical education and trends in health care. As a result of the committee's perception of the evolving health care environment, major changes in the Association's governance were proposed. The debate within the Association on the recommendations of the report led to a tripartite organization of the Council of Deans, the Council of Teaching Hospitals, and the Council of Academic Societies. The Executive Council was expanded to include faculty and teaching hospital executives as well as medical school deans. In 1971, medical students were added to the Association's governance through the Organization of Student Representatives.

It has now been two decades since the last comprehensive review of the Association's governance. The Association's Executive Council recently adopted a new mission statement for the organization and new strategic goals are also being developed. Thus, the Association's elected leadership believes it is prudent to consider whether the current structure best meets the Association's needs and objectives or whether changes in the constituency and the organization suggest modifications.

The Committee on Governance and Structure has been established by action of the Executive Committee and is charged with reviewing the current governance structure of the Association with particular attention to the following issues:

- o the membership on each of the Association's three Councils
- o the participation in the Association by individuals at academic medical centers who are not currently represented on any of the Association's Councils, including, but not limited to vice-presidents for health affairs
- o the role of multi-hospital systems and their executives in the Association
- o the role and composition of the Assembly
- o the composition of the Executive Council



- o the nominating process by which new officers are elected to the Executive Council and Administrative Boards
- o the name of the Association and whether it accurately reflects the organization's membership and purposes
- o the role in the Association beyond election to distinguished service or emeritus membership for individuals who no longer serve on one of the three Councils
- o the fostering of a greater sense of identification with and participation in the Association by members of the Councils and by faculty and administrators of academic medical centers
- o the role of housestaff in the Association
- o the means through which the Association might involve individuals with specific institutional educational responsibilities such as hospital directors of medical education or directors of continuing medical education
- o the Association's existing and possible new Groups and their contributions to the Association's goals

#### 1989-90 CAS NOMINATING COMMITTEE

Representatives from CAS member societies are reminded that the nomination process for the CAS Administrative Board and the position of Chair-Elect of the Council will occur this spring. The CAS Nominating Committee will meet via telephone conference call in May. Individual representatives are encouraged to submit recommendations regarding potential Board members, either directly to members of the Nominating Committee or to the CAS office no later than April 25, 1989. This year, the Nominating Committee will select a clinical scientist as Chair-Elect as well as nominees for four other positions on the Board.

Members of the 1989-90 Nominating Committee are:

Joe Dan Coulter, Ph.D., Chair, Society for Neuroscience  
Ernst R. Jaffe', M.D., American Society of Hematology  
Gordon Kaye, Ph.D., American Association of Anatomists  
Jack L. Kostyo, Ph.D., American Physiological Society  
Barbara McLaughlin, Ph.D., American Society for Cell Biology  
Norman Snow, M.D., Association for Surgical Education  
Paul Van Arsdel, M.D., American Academy of Allergy and Immunology

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

**Framework for Institutional Policies**

**and Procedures**

**to Deal with Misconduct in Research**

March 1, 1989

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## PREFACE

The "Framework for Institutional Policies and Procedures to Deal with Misconduct in Research" was developed during the Summer and Fall of 1988 through the efforts of an interassociation working group. The working group included staff from the Association of Academic Health Centers (AAHC), the Association of American Medical Colleges (AAMC), the Association of American Universities (AAU), the American Council on Education (ACE), the American Society for Microbiology (ASM), the Council on Graduate Schools (CGS), the Council on Government Relations (COGR), the Federation of American Societies for Experimental Biology (FASEB), the National Association of College and University Attorneys (NACUA), and the National Association of State Universities and Land Grant Colleges (NASULGC). The document was revised to reflect the advice of subsequent review groups and tailored to enhance its relevancy to the environment of the academic medical center.

Current efforts by the Public Health Service to develop regulations on misconduct make the issuance of the framework timely, but it would be necessary even if no regulations were forthcoming. This document grows out of the conviction that universities, not the sponsors of research, are responsible for the conduct of their faculty and staff. In order to fulfill that responsibility, they must have fair, workable and expeditious procedures for dealing with alleged transgressions of accepted standards.

We have chosen to offer guidance toward that end by the device of a "framework" rather than by a more prescriptive method. That is only appropriate, given the differing circumstances and existing policies and procedures among our medical schools. An acceptable process will require that all of the main elements of the framework be present, but there is and should be latitude for each institution to find the ways best suited to its condition.

The associations appreciate the financial support of the AAAS/ABA Council on Law and Science for the work of Lisa Poor, Administrative Fellow, Washington University School of Medicine, who worked with association staff in producing this document.

Robert G. Petersdorf, President  
Association of American Medical Colleges

## INTRODUCTION

Researchers at our medical schools and teaching hospitals are engaged in a vast array of projects which hold remarkable promise for the health and well-being of mankind. Guiding these researchers in their pursuit of scientific truths have been the basic and universally-accepted tenets of the process of scientific inquiry and investigation. Key elements of this process are the objective and accurate reporting of data accumulated in the course of experimentation, and verification of research findings to assure valid conclusions. In addition, generally-sanctioned standards of conduct and propriety, when followed, not only assure the integrity of the scientific profession, but engender public support for, and lend credibility to, the scientific endeavor as a whole.

However, recent violations of these principles by a handful of researchers have received wide attention and may undermine the scientific enterprise in ways that go far beyond the waste of public funds. Although an uncommon event relative to the large scientific literature, violations of accepted standards inevitably appear in this as in all human pursuits. Institutions engaged in research have a major responsibility, not only to provide an environment that promotes integrity, but also to establish and enforce policies and procedures that deal effectively and expeditiously with allegations or evidence of scientific misconduct.

In dealing with this problem, it is important to maintain an atmosphere of openness and creativity. Good and innovative science cannot flourish in an atmosphere of oppressive regulation. Moreover, it is particularly important to distinguish misconduct from the honest error and the ambiguities of interpretation that are inherent in the scientific process and are normally corrected by further research.

A little over one year ago, the Association of American Medical Colleges (AAMC) requested its member institutions, to forward copies of their existing policies to address misconduct and it appears that most schools have adopted and published policies to deal with these problems. The primary goal of this document is to assist institutions as they refine such policies or as they move to adopt new ones designed to assure careful and thorough handling of allegations of misconduct. It expands upon the guidelines presented in two 1982 publications: "The Maintenance of High Ethical Standards in the Conduct of Research," by the AAMC, and the "Report of the Association of American Universities Committee on the Integrity of Research," by the Association of American Universities (AAU).

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This document also takes into consideration the 1986 Public Health Service (PHS) guidelines, "Policies and Procedures for Dealing with Possible Misconduct in Science;" and the 1987 regulations issued by the National Science Foundation (NSF), "Misconduct in Science and Engineering Research." The PHS guidelines and NSF regulations describe those agencies' preferred procedures for the institutional handling of allegations of misconduct in research. Those procedures normally have four stages: (1) an inquiry to determine whether the allegation or related issues warrant further investigation, (2) when warranted, an investigation to collect and thoroughly examine evidence, (3) a formal finding, and (4) appropriate disposition of the matter.

It is important to note that any new policies and procedures addressing allegations of violations of the integrity of research must be incorporated into existing institutional policies and procedures for employment and academic conduct. Institutions must be vigilant to provide all parties with appropriate due process. It is reasonable to expect that different situations may require specific accommodations to insure the protection of the rights of all involved individuals. Institutions should be alert to possible harm to any parties throughout the process. An institution may choose, following an investigation, to refer any "findings" to its standing disciplinary procedures, or to develop processes specific to cases of fraud and misconduct in research.

The several stages of an institution's review process are discussed in detail in the remainder of this document. However, it seems useful to identify at the start the imperatives that should guide any institutional review process for dealing with allegations of misconduct or fraud:

- Institutions should ensure that the process used to resolve allegations of fraud not damage science itself.
- Institutions should provide vigorous leadership in the pursuit and resolution of all charges.
- Institutions should treat all parties with justice and fairness and be sensitive to their reputations and vulnerabilities.
- Procedures should preserve the highest attainable degree of confidentiality compatible with an effective and efficient response.

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- The integrity of the process should be maintained by painstaking avoidance of real or apparent conflict of interest.
- The procedures should be as expeditious as possible leading to the resolution of charges in a timely manner.
- Institutions should document the pertinent facts and actions at each stage of the process.
- After resolving allegations, institutions should discharge their responsibilities both internally--to all involved individuals--and externally--to the public, the sponsors of research, the scientific literature, and the scientific community, to the extent that is appropriate and allowable.

#### DEFINITION OF MISCONDUCT IN RESEARCH

There is significant debate within the scientific community and in government about the appropriate scope of policies for dealing with the problem and about the definition of behaviors covered by such policies. Specifically, there is no agreement on the definitions of "fraud" or "misconduct". Until the debate over appropriate scope and definition is resolved, institutions may wish to simply reference in their policies the definitions contained in federal regulation. The PHS has published the following definition in a pending Notice of Proposed Rulemaking (NPRM):

"Misconduct" or "misconduct in science" as used herein is defined as (1) fabrication, falsification, plagiarism, deception or other practices that seriously deviate from those that are commonly accepted within the scientific community for proposing, conducting, or reporting research; or (2) material failure to comply with federal requirements that uniquely relate to the conduct of research.

It should be noted that the AAMC in commenting on the PHS definition opposed the use of such ambiguous language as "other practices that seriously deviate from those that are commonly accepted..." out of concern that novel or innovative practices might be encompassed. However, in formulating such a definition of misconduct, institutions should be aware of the need for policies and procedures to satisfy the legal requirements of applicable regulations. As of this writing, final PHS regulations are not expected to appear before late Spring 1989.



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For institutions receiving NSF funding, it should be noted that that agency defines misconduct as follows:

- (a) "Misconduct" means (1) fabrication, falsification, plagiarism, or other serious deviation from accepted practices in proposing, carrying out, or reporting results from research, (2) material failure to comply with Federal requirements for protection of researchers, human subjects, or the public or for ensuring the welfare of laboratory animals; or (3) failure to meet other material legal requirements governing research.

Some institutional policies may treat certain forms of misconduct, such as fraud (the deliberate misrepresentation of data) or conflict of interest separately. Other institutions may choose to consolidate into a single policy their procedures for dealing with all forms of alleged scientific misconduct. In such a case, the institution may wish to leave the determination of the point at which misconduct becomes fraud or conflict of interest to ad hoc determination on the basis of the particular facts of each case. Such an approach permits the development of an institutional "common law" articulating acceptable scientific research standards. If an institution has separate policies and procedures for dealing with various forms of misconduct, it is suggested that the relevant sections be included in an appendix to the overarching policies and procedures designed to address misconduct.

### **PREVENTION OF MISCONDUCT IN RESEARCH**

While the primary focus of the "framework" document is on providing guidance to institutions in developing or refining objective and workable procedures for investigating allegations of research fraud and misconduct, the ultimate goal of institutions must be to create and maintain an environment in which there is a pervasive attitude of high ethical standards. This climate should serve to eliminate, or at a minimum reduce, dishonest behavior. Institutional policies must therefore delineate measures to be taken to deter and prevent misconduct. These include:

- Procedures for making known to all in the academic community the institution's policies on standards of conduct and sanctions for failure to meet these standards. These standards should be incorporated into written policy, student and faculty handbooks, and contractual agreements. Mechanisms should be established for open discussion of these standards with students, faculty, personnel and administration.

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- Defining roles of officials and faculty having special responsibilities in the prevention of research fraud and misconduct. The director of a laboratory, for example, must have clearly defined responsibilities for reviewing standards with personnel, students and junior investigators and in ensuring proper practices for well-designed experimental protocols and for recording, retaining, and storing research or scholarly research data.
- An institutional policy stating that all authors named on a collaborative study accept full responsibility for the work published or at least for that portion of the research for which they were responsible. Validation of the role of each author should be required.
- Maintaining professional relationships among investigators to assure open discussion of data and research results and freedom of expression leading to enhancement of the climate of integrity and objectivity and avoidance of secrecy and undue competition.
- Encouraging the incorporation of formal coursework, for example seminars on bioethics, into the curriculum, making this subject an integral part of the research and educational experience.

## PROCESS FOR HANDLING ALLEGATIONS OF MISCONDUCT IN RESEARCH

### INITIATION OF AN INQUIRY

The responsibility to pursue an allegation of misconduct in research belongs to the institution and must be carried out fully to resolve questions regarding the integrity of the research. Even in the absence of a specific complaint, the institution should be alert to questionable academic conduct that might raise legitimate suspicion of fraudulent research. In the inquiry and any investigation which may follow, the institution should focus on the substance of the issues and should be vigilant not to permit personal conflicts between colleagues to obscure the facts.

In order to address all allegations of misconduct in research expeditiously, an institution should designate one or more senior academic or administrative officials to whom allegations should be reported. Universities and medical schools should delegate this responsibility according to the needs of their own organizational structure. The designated individual(s) could also (1) provide education about scientific misconduct, (2) interpret the institution's misconduct policy, (3) counsel staff, and (4) disseminate the policy. The

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designated senior official(s) should pursue all allegations to resolution. If there is a conflict of interest, the case should be referred to an alternate senior official. To avoid unnecessary delays and confusion, it is advisable to predetermine the administrative alternate(s).

Institutional policies should clearly state that the senior academic or administrative official will counsel confidentially any individual who comes forward with an allegation of misconduct. Some concerns brought to the senior official's attention may not fall within the scope of the policies and procedures developed to address misconduct. Regardless of the nature of the concern, the senior official should seek to assist in its resolution through institutional processes appropriate to the particular case, such as referral to the department chair, the personnel office, or the faculty grievance procedure. If the senior official determines that the concern is properly addressed through policies and procedures designed to deal with misconduct in research, the inquiry and investigation procedures should be discussed with the individual who has questioned the integrity of a research project. If the individual chooses not to make a formal allegation but the senior official believes there is sufficient cause to warrant an inquiry, the matter should be pursued; in such a case, there is no "complainant" for the purposes of this document.

Even if the respondent, or subject of the allegation, leaves the institution before the case is resolved, the institution has a responsibility to continue the examination of the allegations and reach a conclusion. Further, an institution should cooperate with the processes of other involved institutions to resolve such questions.

## **INQUIRY**

### **A. Purpose**

Whenever an allegation or complaint involving the possibility of scientific misconduct is made, the designated senior official should initiate an inquiry--the first step of the review process. In the inquiry stage, factual information is gathered and expeditiously reviewed to determine if an investigation of the charge is warranted. An inquiry is not a formal hearing; it is designed to separate allegations deserving of further investigation from frivolous, unjustified, or clearly mistaken allegations.

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**B. Structure**

The inquiry process may be handled with or without a formal committee. The AAMC recommends a standing committee for reasons of institutional memory, but it recognizes that certain institutions may prefer an alternative approach. Regardless of the approach taken, it is the responsibility of the senior official to make every effort to ensure that the inquiry is conducted in a fair and just manner. The inquiry phase is critical; institutions should consider whether more than one person should be involved in conducting the inquiry. If the committee method is utilized, the committee should be formed under the guidelines presented in the investigation section (see page 9).

Individuals chosen to assist in the inquiry process should have no real or apparent conflicts of interest bearing on the case in question. They should be unbiased, and have appropriate backgrounds for judging the issues being raised.

Institutions should consult their own legal counsel to minimize the risk of liability for actions taken in the conduct of the inquiry and investigation. Institutions should also make clear any policies on providing legal counsel to complainants and respondents.

**C. Process**

Upon initiation of an inquiry, the senior official is responsible for notifying the respondent within a reasonable time of the charges and the process that will follow. If the committee method is to be used, the committee members should be appointed and convened.

Whether a case can be reviewed effectively without the involvement of the complainant depends upon the nature of the allegation and the evidence available. Cases that depend specifically upon the observations or statements of the complainant cannot proceed without the open involvement of that individual; other cases that can rely on documentary evidence may permit the complainant to remain anonymous. While it may be desirable to keep the identity of the complainant confidential during the inquiry phase, local laws which provide for open access to certain records may make such confidentiality impossible. During the inquiry, confidentiality is desirable in order to protect the rights of all parties involved.

The senior official should assume responsibility for disseminating the facts of the case to the appropriate individuals. Normally notification should be made in writing and copies

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filed in the office of the senior official. The safety and security of all documents must be assured.

When the inquiry is initiated, the respondent should be reminded of the obligation to cooperate by providing material necessary to conduct the inquiry. Institutional policies should state clearly that uncooperative behavior may result in an immediate investigation and other institutional sanctions.

Each institution should develop policies regarding the role of legal counsel in this and other phases of these proceedings. The AAMC advises against the use of legal counsel at this stage, but recognizes that particular circumstances may necessitate it. Those responsible for conducting the inquiry must be aware of the institution's policies.

Due to the sensitive nature of allegations of scientific misconduct, institutions should strive to resolve cases expeditiously. Deadlines should be established to facilitate the process. It is recommended that the inquiry phase be completed within 60 days or less of the initial notification of the respondent. A 60-day period is consistent with the 1986 PHS guidelines and the 1987 NSF regulations. If the committee, or whatever body is convened, anticipates that the established deadline cannot be met, a report, citing the reasons for the delay and progress to date, should be submitted for the record and the respondent and appropriately involved individuals should be informed.

#### D. Findings

The completion of an inquiry is marked by a determination of whether or not a formal investigation is warranted. There should be written documentation to summarize the process and state the conclusion of the inquiry. The respondent should be informed by the senior official whether or not there will be further investigation. If there is a complainant, he or she should be likewise informed. Allegations found to require investigation should be forwarded promptly to the investigative body. Federal regulation requires that the agency sponsoring the research should also be notified at this point.

If an allegation is found to be unsupported but has been submitted in good faith, no further formal action, other than informing all involved parties, should be taken. The proceedings of an inquiry, including the identity of the respondent, should be held in strict confidence to protect the parties involved. If confidentiality is breached, the institution should take reasonable steps to minimize the damage to reputations that may result from

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inaccurate reports. Policies should state that allegations that have not been brought in good faith may lead to disciplinary action.

The institution should seek to protect the complainant against retaliation, including protecting anonymity whenever possible. Those early in their careers, with less authority are particularly vulnerable. Individuals engaged in acts of retaliation should be disciplined in accordance with the appropriate institutional policies.

## INVESTIGATION

### A. Purpose

An investigation should be initiated within 30 days when an inquiry determines that it is warranted. The purpose of an investigation is to explore further the allegations and determine whether misconduct has been committed. In the course of an investigation, additional information may emerge that justifies broadening the scope of the investigation beyond the initial allegations. The respondent should be informed when significant new directions of an investigation are undertaken. The investigation should focus on accusations of misconduct and examine the factual materials of each case.

### B. Structure

The investigative body may take any of several forms: an ad hoc committee to handle one specific case, a combination of a standing committee and one-time only appointed members, or a standing committee. Here again, the AAMC recommends a standing committee for purposes of institutional memory. Members of the investigative body may be chosen from within or outside of the institution, as circumstances dictate.

Regardless of the structure chosen, conflicts of interest must be examined scrupulously and any relationship with parties to the matter must be fully disclosed and made visible to all those involved and having an interest in the investigation. Those investigating the allegations should be selected in full awareness of their closeness of their professional affiliation with the complainant or the respondent. Any member of a standing committee or who has an unresolvable conflict of interest in a given case should not be permitted to be involved in any aspect of the committee's handling of that case.

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Whether a standing committee or an ad hoc committee is utilized, it is important that the committee have appropriate scientific expertise to assure a sound knowledge base from which to work.

### C. Process

Upon receipt of inquiry findings that an investigation is warranted, the senior official should initiate investigation within 30 days, and the complainant and respondent should be notified of the investigation. All involved parties are obligated to cooperate with the proceedings in providing information relating to the case. All necessary information should be provided to the respondent in a timely manner to facilitate the preparation of a response. The respondent should have the opportunity to address the charges and evidence in detail. The institutional procedures should address the role of legal counsel in the investigation.

Institutions may wish to adopt, as a matter of policy, a mechanism that would allow interim administrative action to be taken when justified by the need to protect the health and safety of research subjects and patients, or the interests of students and colleagues. Administrative action could range from slight restrictions to suspension of the activities of the respondent.

As previously noted, federal regulations require that the agency sponsoring a research project in which misconduct is suspected should be notified as soon as the decision has been made to undertake a formal investigation. It is recommended that this practice be extended to include notification of all sponsors of the research. The institution may wish, in turn, to seek assurances of the confidential treatment of this information. Significant developments during the investigation, as well as the final findings of the committee, should be reported to the sponsor. When the investigation is concluded, all entities initially notified of the investigation should be informed of its final outcome.

An institution's policy should require that an investigation be conducted as expeditiously as fairness and thoroughness permit. The adoption of a specified time period of 120 days for the completion of an investigation is recommended, to reflect the seriousness with which an institution views accusations of misconduct and to be in compliance with PHS guidelines and NSF regulations. However, an institution may choose to acknowledge formally in its procedures that the nature of some cases may render the time period difficult to meet. It should be noted that an institution's ability to complete an investigation within a specified time period will depend heavily upon factors such as the

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volume and nature of the research to be reviewed and the degree of cooperation being offered by the subject of the investigation. An institution may choose to specify interim reporting to monitor the progress of an investigation. If the deadline cannot be met, an interim report should be submitted to the senior official with a request for an extension.

#### **D. Findings**

The findings of the investigative committee must be submitted in writing to the senior official. The respondent should receive the full report of the investigation. When there is more than one respondent, each shall receive all those parts that are pertinent to his or her role. All federal agencies, sponsors, or other entities initially informed of the investigation also must be promptly notified of the findings. The institution should retain the findings of the investigation in a confidential and secure file.

Investigations into allegations of misconduct may result in various outcomes, including:

1. A finding of misconduct;
2. A finding that no culpable conduct was committed, but serious scientific errors were discovered;
3. A finding that no fraud, misconduct or serious scientific error was committed.

Thus, an investigation of misconduct may disclose evidence that requires further action even in those cases in which no fraud or misconduct is found.

If an investigation has been launched on the basis of a complaint, and no fraud or misconduct is found, no disciplinary measures should be taken against the complainant and every effort should be made to prevent retaliatory action against the complainant if the allegations, however incorrect, are found to have been made in good faith. If the allegations are found to have been maliciously motivated, disciplinary actions may be taken against those responsible.

#### **APPEAL/FINAL REVIEW**

Institutions should provide respondents with an appeals process at this point through a written appeal of the investigative committee's decision. Appeals should be restricted



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to the body of evidence already presented, and the grounds for appeal should be limited to failure to follow appropriate procedures in the investigation or arbitrary and capricious decision making. New evidence may warrant a new investigation. The appeal should be filed promptly after a finding has been made. The institution should specify a senior administrative official (e.g., Provost) not involved in the decision of the investigative body to hear the appeal. After an appeal is concluded, an institution may also wish to provide for a final review by its chief executive officer or designee. The institution should note that the decision of the review is final.

### **DISPOSITION**

Responsibility for determining the nature and severity of disciplinary action should be specified in an institution's policy. This may be done through the institution's regular faculty disciplinary or grievance procedures. Many actions may be available to the institution and should be taken in a fashion consistent and commensurate with the nature of the proven acts of misconduct. Examples include:

- Removal from a particular project
- Letter of reprimand
- Special monitoring of future work
- Probation
- Suspension
- Salary reduction
- Rank reduction
- Termination of employment

Consideration also should be given to formal notification of other concerned parties not previously notified as to the outcome of the case. These parties may include:

- Sponsoring agencies, funding sources
- Co-authors, co-investigators, collaborators
- Editors of journals in which fraudulent research was published
- State professional licensing boards
- Editors of journals or other publications, other institutions, sponsoring agencies, and funding sources with which the individual has been affiliated.
- Professional societies
- Where appropriate, criminal authorities

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The possibility exists that during the course of the investigation, the individual involved may resign from employment. In this instance, the investigation should continue to its full conclusion. Also, once dismissed or resigned from an institution, an individual found guilty of scientific misconduct may move on and engage in dishonest activities elsewhere. Thus, it is an institutional responsibility to check thoroughly the references, licensing and accreditation status of all new faculty and clinical staff. As for grantees, federal regulations are already in place to identify individuals who have been debarred or suspended from receiving federal grant or contract funds.

### CONCLUSION

Federal regulations governing the handling of cases of scientific misconduct are still in a process of evolution. Thus, this document, and institutional policies, must change over time to conform to the evolving regulatory environment. Regardless of these patterns of change, it is imperative that medical schools, and all research institutions, treat allegations of scientific misconduct seriously and not only develop, but implement policies and procedures to provide for a fair and expeditious handling of these accusations. The process need not require the development of an elaborate administrative bureaucracy and in many cases can build on existing expertise and committee structure. Though many, and perhaps most, of the allegations will be ungrounded, all suspected cases of misconduct must be brought into light for what they are if the public confidence in the integrity and value of scientific research is to be preserved.

The AAMC continues to work on various aspects of this issue and invites commentary on this document and other facets of research misconduct in which we may play an effective role.

### REFERENCES

U.S. Public Health Service, "Policies and Procedures for Dealing with Possible Misconduct in Science." NIH Guide for Grants and Contracts, July 18, 1986.

National Science Foundation, "Misconduct in Science and Engineering Research." First appeared 52 FR 24466, codified Title 45 Code of Federal Regulations Part 689.

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Association of American Medical Colleges, The Maintenance of High Ethical Standards  
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Committee on the Integrity of Research, Washington, D.C. 1982.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
IMMEDIATE ACTION REQUESTED

MEMORANDUM #89-14

February 28, 1989

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

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

SUBJECT: Medicare Proposed Regulations on Payment for Physician Services  
Furnished in Teaching Settings

\*\*\*\*\*

\* ABSTRACT \*

\* \*

\* These regulations propose to revise Medicare rules on paying physicians \*  
\* in teaching settings. They cover the following areas: 1) attending \*  
\* physician criteria and medical record documentation; 2) the method \*  
\* by which fees will be calculated for teaching physicians; and 3) \*  
\* payment to providers for compensation paid to physicians for \*  
\* administrative and supervisory services. This memorandum includes \*  
\* a synopsis of the major provisions of the rules and the Association's \*  
\* initial commentary. The AAMC urges all members to carefully review \*  
\* the impact of the proposed rules on their own institutions and to \*  
\* submit comment letters to HCFA. In particular, the proposal to \*  
\* offset against hospital costs the physician fees retained by a \*  
\* hospital, related medical school or related faculty practice plan, \*  
\* should be closely scrutinized. A copy of the proposed rules is \*  
\* attached. \*

\*\*\*\*\*

On February 7, the Health Care Financing Administration (HCFA) issued the long awaited regulations proposing policies to pay for physician services furnished in teaching settings (54 Federal Register 5946-5971). The rules also cover payment for consultative pathology and radiology services furnished to patients in all providers, including teaching hospitals.

Comments will be considered by HCFA if received before 5:00 p.m. on April 10, 1989. Please mail your comments to:

Administrator  
Health Care Financing Administration  
Department of Health and Human Services  
Attention: BERC-142-P, P.O. Box 26676  
Baltimore, Maryland 21207.

A copy of your comments to HCFA should also be forwarded to: G. Robert D'Antuono, Staff Associate, Division of Clinical Services, AAMC, 1 Dupont Circle, NW, Suite 200, Washington, D.C. 20036.

## I. Legislative History of Physician Services in Teaching Hospitals

The proposed rules would elevate to regulatory status existing criteria contained in Intermediary Letter (IL) 372, issued in April, 1969. IL 372 sets forth specific conditions that physicians in teaching settings must meet to be considered attending physicians and qualify for charge payment for their services under Medicare Part B. It also specifies how carriers are to determine the reasonable charges for these services.

In 1972, Congress amended the Social Security Act and enacted Section 227 of P.L. 92-603 which authorized payment of physician services in teaching hospitals on a reasonable cost basis, except under certain circumstances, and provided financial incentives if all physicians elected to be paid for professional services on a reasonable cost basis. While the provisions of Section 227 allowing cost-based payments were implemented, regulations to implement charge-based payments were proposed in 1974 and 1978 but not implemented. In 1980, new legislative provisions (Section 948 of P.L. 96-499) were enacted specifying the requirements for billing of services performed by teaching physicians and guidelines on allowable charges. The February 7 regulations are proposed to implement Section 948.

## II. Major Provisions of Proposed Rules

HCFA has prepared a flow chart to facilitate reading the proposed regulations. When reading this summary or HCFA's proposal, it may be helpful to refer to the chart on page 5951.

### A. Eligibility for Charge-Based Payment

**A-1. Hospital Eligibility.** In order for teaching physicians in a hospital to qualify for payment under the charge-based rules, the hospital must demonstrate that at least 25% of non-Medicare patients pay at least 50% of their charges. If the hospital meets the 25/50 test and all physicians are teaching physicians, then payment will be based on the special customary charge rules, explained in section B below.

The proposed regulations presume that Medicaid patients pay full charges. While this helps hospitals meet the eligibility test where a state Medicaid program covers a large percentage of the indigent, it provides only limited help in certain states where relatively few people are eligible for Medicaid.

It is our understanding that if this test is not met by the hospital, then all physicians who receive a salary from the hospital would be paid under the compensation-related charge rules (see pg. 5961), whether or not they "elect" to do so. If physicians are not compensated by the hospital and the hospital is not able to meet the 25/50 test, then physician payment would be determined using the general reasonable charge rules (i.e. Medicare's Customary, Prevailing and Reasonable method). In this circumstance, the physician's customary charge would be lowered to reflect the fact that many patients pay no fee or only a nominal fee.

To facilitate compliance with the 25/50 requirement, HCFA wishes to develop a "presumptive test" based on the hospital's mix of patients and payment levels of other third party payers. The use of a presumptive test would minimize possible requirements that hospitals must collect and aggregate data from individual physicians. HCFA invites comments on how to develop a methodology for the presumptive test as well as for calculating the customary charges.

A-2. **Attending Physician Criteria.** The physician criteria as outlined in Intermediary Letter 372 have been revised (1) with additional criteria for all residency programs in general and (2) special criteria to accommodate residency training programs in family practice, psychiatry and anesthesiology. Under IL-372, an attending physician is expected to:

- review the patient's medical history, physical examination and record of tests and therapies in the hospital;
- personally examine the patient;
- make or confirm the admission diagnosis;
- determine the course of treatment;
- be recognized by the patient as his/her personal physician;
- assume responsibility for the continuity of the patient's care;
- when a surgical procedure or a complex medical procedure is performed, be ready to furnish any services that would be furnished by the patient's personal physician in a non-teaching hospital; and
- personally direct interns and residents who furnish services to the patient.

Additional general criteria added are: 1) the physician must personally examine the patient on a regular basis during the hospital stay; and 2) the physician must be expected by the patient to furnish, or arrange for others to furnish, any care the patient may require immediately after discharge.

**Outpatient Services.** HCFA is proposing to modify the attending physician requirements for services in all outpatient settings, including family practice and emergency department settings. Under the proposed rules, the attending physician must: 1) direct interns and residents who furnish services to the beneficiary from such proximity as to constitute immediate availability; 2) assure that these services are appropriate; and 3) review the beneficiary's medical history, physical examination and record of tests and therapies that are received.

It should be noted that the attending physician criteria for inpatient services involving a family practice resident are not different from those of other specialties. However, since HCFA in the proposed rules, has acknowledged that the focus of training in family practice is for the resident to be recognized by the patient as the attending physician, the AAMC feels that this may be a good opportunity to negotiate with HCFA to expand the outpatient criteria described above to family practice inpatient services as well. Therefore, the AAMC is advising members with family practice programs to comment on this point.

**Psychiatry.** In recognition of the physician-patient relationship established by residents in psychiatry, the general criterion requiring that the attending physician be recognized by the patient is not applicable to psychiatrists in the care of these patients.

**Anesthesiology.** For anesthesiology, special criteria state that the attending physician relationship would be established if the anesthesiologist directs no more than two (2) concurrent procedures involving residents or a "mix" of no more than one resident and one certified registered nurse anesthetist (CRNA). At present, the attending anesthesiologist can supervise and bill for four (4) concurrent procedures.

**A-3. Documentation Requirements.** Medical record documentation requirements are also being more completely specified. The medical record must contain signed or countersigned notes by the attending physician that show he/she personally: 1) reviewed the beneficiary's medical history; 2) performed a physical examination; 3) confirmed or revised the diagnosis; 4) visited the patient during the more critical period of illness; and 5) discharged the patient. With respect to other services, the medical record must contain a notation made by an intern, resident, or nurse that indicates that the physician was physically present when the required service was furnished.

For outpatient visits the general documentation requirements for attending physicians do not apply; however, documentation must include notes signed by the faculty physician that reflect the extent of participation in services furnished.

**B. Physician Fees.** HCFA is proposing special customary charge rules for teaching physicians. As required by law, the customary charge for professional medical services provided by a teaching physician would be based on the greatest of:

- the charges that are most frequently collected in full or substantial part (more than 50%) from non-Medicare insured patients;
- the mean charges that are collected in full or substantial part from non-Medicare insured patients; or
- eighty-five percent (85%) of the prevailing charges paid for similar services in the same locality or ninety percent (90%) of the prevailing charges if all teaching physicians in the hospital agree to accept assignment.

For this purpose, a teaching physician is a "physician who is compensated by a hospital, medical school, other affiliated entity or professional practice plan for physician services furnished to patients, and who generally involves interns and residents in patient care." A community physician who also practices in a teaching hospital and meets the definition of a teaching physician would be paid under the special customary charge rules shown above for both teaching patients and for all private, non-teaching patients admitted to the hospital.

**C. Payment to Providers for Compensation Paid to Physicians Who Furnish Services to Providers.** According to statutory regulations, Medicare may not pay more than the reasonable cost of services, (ie. the actual cost incurred by providers to

deliver patient care). On this basis, HCFA is proposing to effectively reduce allowable compensation costs to physicians claimed by teaching hospitals on the annual cost report under certain circumstances. Under the proposed rule, when a physician is compensated by a provider for providing services which benefit patients generally (services other than direct medical/surgical care to individual patients) and, is required by the hospital or related organization, such as a faculty practice plan, to return a part of the revenue received for services to individual patients to the provider, this portion will be treated as a reduction to the hospital's allowable costs for physician compensation.

HCFA would calculate the hospital's reduction to allowable costs as follows:

The retained revenue for a physician for direct patient care services would be offset against that physician's compensation for services to the provider on the basis of the ratio of the physician's time spent in furnishing general services (to the provider) to total time spent in all categories of service. Time spent in direct patient care services is excluded from the calculation.

The AAMC opposes this proposal and presents its views in the "Interpretation and Commentary" section of this memorandum.

#### D. Other Issues

D-1. Reasonable Compensation Equivalent Limits. Allowable compensation for services furnished by physicians is subject to "reasonable compensation equivalent (RCE) limits. Under these limits, Medicare reimbursement is determined based on the lower of the actual cost of the services to the provider or an RCE. RCE limits are not applied to reimbursement for direct medical/surgical services which are reimbursable on a reasonable charge basis. Rather than updating the RCE limits annually, HCFA is proposing that RCE limits be reviewed annually and updated only if a significant change in the limits is warranted.

D-2. Payment for Consultative Pathology Services. HCFA proposes not to allow a hospital or medical staff to use a "standing order policy" in lieu of the individual attending physician order for personal consultative services written by the pathologist. As proposed, the consultation request must be made by the attending physician (not the resident) and on a case by case basis, as deemed medically necessary.

E. Miscellaneous. The remaining proposed regulations maintain the continuation of existing rules for radiology and outpatient services. Also continued is the option for physicians in a teaching hospital to elect payment on a reasonable cost basis for physician services rather than a reasonable charge basis. Provisions are also being proposed to continue reimbursing on a formula basis, the direct medical/surgical services provided by voluntary staff of a teaching hospital where all physician services are paid on a cost basis. The method would calculate "salary equivalent" payments for the patient care services of voluntary staff.



## F. Interpretation and Commentary

1. The Association is most concerned with the section of the proposed rule, "Payment to Providers for Compensation Paid to Physicians Who Furnish Services to Providers" as discussed in Section III, page 5954 of the Federal Register (copy attached) which could offset physician practice revenues against hospital costs. After a recent meeting with representatives from HCFA, we were able to clarify the intent of this section.

Key to this section is how "related organization" is defined, since it is this relationship which would be responsible for requiring an "offset" under the proposed rules. Depending on how an academic medical center is organized, the medical school and/or faculty practice plan may NOT be a "related organization" to the hospital. The organizational models below illustrate when an "offset" may be required:

**Model:** Hospital, Medical School and Practice Plan are one organization.  
**Comment:** Offset required.

**Model:** Hospital, and Medical School are one organization but Practice Plan is a separate organization, (i.e. not owned or controlled by hospital or school).

**Comment:** Possible offset. Depends on how money is transferred from the plan to the hospital or school and if there is a contractual requirement that the plan make payment to the school.

**Model:** Hospital is one organization. Medical School and Plan are another organization.

**Comment:** No offset.

**Model:** Hospital, Medical School and University are all separate organizations.

**Comment:** No offset.

**Model:** Hospital (or physician group owning a hospital) employs all physicians on a salaried basis and bills all professional services on a charge basis.

**Comment:** Offset required.

**Model:** Hospital is a community teaching hospital and employs 24 hour "on-call", salaried physicians to provide direct medical/surgical services and, on an as needed basis, supervise and teach residents. The hospital bills fees on a charge basis and retains all professional fee income.

**Comment:** Offset required.

It should be noted that in cases where the hospital claims faculty costs on a related organization basis (eg. through an A-8 adjustment on the hospital cost report) special care must be taken to examine whether the historical practice of claiming faculty costs may lead HCFA to presume that a practice plan offset should be required.

The impact of this rule could be either minimal or substantial. Minimal impact is anticipated if the offset is applied only to physician services now paid by Medicare on a cost reimbursement basis. This would include physician services, such as, administration or unit management, in PPS-exempt hospitals and PPS-exempt units, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and outpatient clinics. The impact of the offset will be substantial if HCFA decides to apply the rule retroactively to 1984 base year cost reports used to determine the per resident payment under the new direct medical education rules. If applied retroactively, net practice plan revenues would greatly reduce the allowed cost for faculty teaching and supervision of residents.

The AAMC feels strongly that the offset should be opposed by AAMC members for a number of reasons: 1) historically, HCFA has never indicated in published rules, a clear and consistent precedent for this requirement; 2) Medicare is prohibited by statute from using Part B funds to subsidize Part A expenses; and 3) the offset rule mitigates a teaching hospital's right under HCFA's March 8, 1983 rules for "Medicare Payment for Physician Services in Hospitals, SNFs, and CORFs" to receive charges for physicians' services in excess of the compensation amount paid the physician. If HCFA fails to modify the final rule to eliminate the offset, the AAMC believes that the offset should only be applied prospectively.

The AAMC strongly recommends members write HCFA and oppose the offset of faculty practice revenues. The Association feels this it is inappropriate social policy to discourage teaching physicians from contributing a percentage of their income toward the support of their medical schools. If adopted, the proposal will serve only to increase school operating costs by encouraging faculty to retain all fee income.

2. A second issue in the proposed rules is the absence of guidelines with respect to the updating of the reasonable compensation equivalent (RCE) limits. The AAMC favors a policy whereby HCFA would be required to publish the RCE's any time one or more specialties change more than 2%.

3. A third issue is related to data requirements for documenting collection rates at or above the 85% prevailing charge under the "special customary charge" rules. The Association encourages members to assess hospital and physician patient accounting systems to determine if compliance is possible.

For additional information, please contact: G. Robert D'Antuono, Division of Clinical Services, 202-828-0490.

cc: Group on Faculty Practice  
Group on Business Affairs (Principal Financial Officers)  
AAHC Members

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #88-41

October 13, 1988

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

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

SUBJECT: Proposed Regulations on Medicare's Payment for Direct  
Graduate Medical Education Costs

On September 21, 1988 the Health Care Financing Administration (HCFA) issued a proposed regulation entitled "Changes in the Payment Policy for Direct Graduate Medical Education Costs." There is a 60 day comment period. All comments must be received by 5 P.M. on November 21, 1988 at the Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-375-P, P.O. Box 26676, Baltimore, MD 21207.

Below you will find a synopsis of the major provisions of the proposed rule. A complete copy of the rule is also attached. For additional information please call Ivy Baer, Division of Clinical Services, 202-828-0490. Please send copies of your comment letters to HCFA to Ivy Baer, AAMC, 1 Dupont Circle, Suite 200, Washington, D.C. 20036.

I. Legislative History

The proposed regulation implements section 9202 of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) and section 9314 of the Omnibus Budget Reconciliation Act of 1986 (OBRA). COBRA adds two new sections to the Social Security Act ("the Act"):

- o Section 1861(v)(1)(Q) states that "except as explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical education activities."
- o Section 1886(h) sets out specific rules for the payment of direct graduate medical education costs and includes provisions for counting full time equivalent (FTE) residents, an exceptions process for hospitals that did not have an approved residency program during the base period but subsequently established one, weighting factors based on years of residency in various specialties, special

rules for foreign medical school graduates  
(FMGs), and a definitional section.

OBRA amends section 1886(h)(6) of the Act to set out a method for determining how to count a resident who, as part of the residency program, spends time in patient care in outpatient settings.

The proposed rule will apply only to costs associated with approved medical, osteopathic, dental and podiatric residency programs. It will not apply to indirect graduate medical education payments or to approved nursing and allied health training programs.

II. Major Provisions

1. Calculations for Determining Direct GME

Effective, July 1, 1985, the determination of Medicare's payment for direct GME costs involves three calculations:

- a. (an inflation adjusted per resident amount) x (weighted number of full time equivalent residents) = aggregate approved amount
- b. (aggregate approved amount) x (Medicare inpatient days ÷ total inpatient days) = Medicare's share of direct GME
- c. Medicare's share is apportioned between Part A (hospital insurance) and Part B (supplementary medical insurance).

Medicare will pay 100% of the Part A amount and 80% of the Part B amount.

Each of these computations is described below.

2. Determination of Aggregate Approved Amount

a. Updated per Resident Amount

COBRA requires the calculation of a hospital-specific per resident amount be determined for each provider. The numerator for the calculation is based on the provider's allowable costs for its cost reporting period beginning during Federal FY 1984 (October 1, 1983 through September 30, 1984).

The preamble to the regulation is likely to cause confusion and may lead to different interpretation about how the denominator will be computed. At one point HCFA states in the preamble that "for purposes of this rule we are proposing to use the number of residents reported on the Federal FY1984 cost report under indirect GME payment rules as the denominator in calculating base-period average per resident amounts." (emphasis added) However, elsewhere in the preamble and in the regulation itself, it is proposed that the per resident amount be determined "by dividing the allowable graduate medical education costs for the provider's cost reporting period beginning on or after October 1, 1983 but before October 1, 1984, by the number of FTE residents reported on the provider's cost report for that cost reporting

period." The specific cost report line number for the FTE residents is not provided.

For cost reporting periods beginning October 1, 1983, through May 31, 1984, the average per resident cost will be updated by the Consumer Price Index (CPI-U) to account for inflation in the year between the base period and the first fiscal year subject to the proposed regulations. For cost reporting periods beginning June 1, 1984 through September 30, 1984, no update is necessary because the base period is followed immediately by first cost reporting period subject to the proposed regulations. For all cost reporting periods beginning on or after July 1, 1985, but before July 1, 1986, the per resident amount determined for the base period is to be updated by one percent. For cost reporting periods after 7/1/86 the amount will be updated based on changes in the CPI-U.<sup>1</sup>

b. Counting Full-Time Equivalent Residents

(1) Approved Medical Residency Program

The Act defines an approved medical residency program as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty..." The proposed regulation defines an approved program as one "that is approved by one of the national accrediting bodies set forth in section 1861(b)(6) of the Act or that may be counted toward certification in a specialty or subspecialty cited in the 1985-1986 Directory of Residency Training Programs published by ACGME." The only national accrediting body listed for physician residencies is the Accreditation Council for Graduate Medical Education (ACGME). Furthermore, any fellowship program that meets the requirements of an approved program in geriatric medicine as defined by the Secretary will also be included in this definition. Fellows in approved programs will be paid for on the same basis as residents in approved programs.

For residents or fellows who are in programs neither listed in the '85-'86 "Green Book," nor now approved by the ACGME, hospitals are paid up to 80% of the reasonable costs of services (salaries and salary-related fringe benefits) after payment of the Part B deductible by the Medicare beneficiary. No program overhead costs in connection with such residents are payable.

(2) Limit on Years Residents Are Counted as FTEs

The proposed rule defines FTEs based on the total time necessary to fill a residency position rather than on a specific number of hours worked. If a resident spends time in more than one hospital, the resident's time is to be prorated between or among the hospitals where he/she works. Part-time residents will be counted based on the proportion of time worked compared to the average time spent by others in the same year training in the same specialty program.

In determining the FTE count, HCFA proposes to exclude from a hospital's resident FTE count residents for whom the hospital incurs no salary/stipend

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<sup>1</sup>See Appendix I for chart setting out proposed updates per FTE

costs, such as residents in Veterans Administration or Department of Defense programs at civilian hospitals or residents whose stipend is paid solely with University or practice plan funds.

For residency periods beginning on or after July 1, 1987, the time spent by a resident in a non-hospital setting will be counted if two conditions are met: (1) there is a written agreement between the hospital and the non-hospital provider to the effect that the hospital pays for the resident's compensation in the outside setting and (2) the resident's time is spent in patient care activities.

### (3) Weighting Factors

Weighting will involve two factors: an overall limit on the number of years that a resident may be counted as one FTE and whether a resident is a graduate of a foreign medical school.

#### (a) "Initial Residency Period"

The weighting factor for the "initial residency" period will be 1.0. The initial residency period is the minimum period needed for board eligibility plus one year, not to exceed a total of five years. As required by the Act, the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education will be used to determine the period of board eligibility. If a residency requires five years, such as surgery, the weight of 1.0 will be attached to the full five years but not to an additional year, so that the total number of years does not exceed the maximum five year period.

As required by the Act, geriatric fellowship programs will be an exception to the initial residency period. Time spent in a geriatric fellowship program will not be counted against a resident's initial residency period. In other words, an individual will be fully counted during the basic specialty program needed to gain entrance to a geriatric fellowship, the geriatric fellowship itself, and one additional year.

If a transitional year is required for a residency, such as the clinical base year needed before training can begin in anesthesiology, the transitional year is added to the years needed for the specialty training itself to determine the necessary years for the training program, as long as the total does not exceed five years. If a resident does a transitional year simply to gain a broader base of clinical experience and the transitional year is not required by the resident's specialty, then the transitional year counts as the additional year beyond the minimum number of years of training that is required for board certification.

If a resident switches residency specialty programs, the "initial residency period" will be counted using the period of time allotted to the first residency, plus one year.

If a resident is not in an initial residency period the weighting factor will be .75 from July 1, 1986 through June 30, 1987 and .50 thereafter.

#### (b) Counting FMGs

Under the Act, a resident who is an FMG and who otherwise qualifies by being in an initial residency period will be considered to have a weighting factor of 1.0 only if the individual has passed parts I and II of the Foreign Medical Graduate Examination in Medical Sciences or has received a certification from, or passed an examination of, the Educational Commission for Foreign Medical Graduates before July 1, 1986. Any FMG whose residency begins on or after July 1, 1986 and who by the date the residency begins has not met the criteria for FMGs will not be counted at all. Once the criteria are met, the FMG will be counted on the same basis as any other resident for the remainder of his or her program.

(4) Medicare's Share of Direct GME Costs

a. Patient Load

To determine Medicare's share of GME costs to be paid to a hospital or health care complex, the proposed rule calls for a calculation that is made by dividing total Part A inpatient hospital days by total, inpatient hospital days (i.e., both Medicare and non-Medicare inpatient days). This will determine the Medicare patient load. The rule proposes that for a "health care complex" the Medicare patient load for the hospital portion of the complex be used as the Medicare payment share for the complex as a whole. The inpatient days would include inpatient days of the hospital that are payable under Part A and would exclude inpatient days applicable to hospital based skilled nursing facilities and intermediate care facilities.

(5) Misclassified and Nonallowable Costs

Due to a concern that in the past "there have been some questionable costs erroneously reimbursed through the direct medical education pass through", HCFA is proposing to add provisions about misclassified and nonallowable costs. Misclassified costs were treated in the base period as allowable GME costs, but should have been paid as allowable operating costs. For example, if the salary for a physician who managed the intensive care unit and did no resident supervision was reported as a GME cost, the physician's salary would be reclassified as an allowable operating cost. A nonallowable cost is a cost which may not be reported as either a GME cost or an allowable operating cost. Examples of nonallowable costs are the costs of a medical school related to a hospital by common ownership or control that are not directly related to patient care furnished in the hospital and physician compensation costs that should be paid on a Part B reasonable charge basis.

HCFA will instruct intermediaries to reexamine Federal FY1984 GME costs and to request supporting documentation in questionable cases. HCFA is proposing starting the review and reaudit before the publication of the final rule. Hospitals will be able to appeal HCFA's determination of the propriety of their base period amounts. Appeals of average per resident amounts are limited to appeals of the FY1984 GME costs or resident counts. HCFA is proposing that the request for an intermediary to reexamine the classification of costs must be made "within 180 days of the notice by the intermediary that its base-period average per resident amount reflects the exclusion of costs from the base period because of misclassification."

In the case of misclassified costs, the rule proposes the reopening of settled cost reports for the sole purpose of correcting a misclassification of operating costs as GME costs. The hospital may request a modification of its hospital specific rate when its cost report contains misclassified costs. Overpayments will not be recouped nor underpayments paid for PPS years no longer subject to reopening; however, payments may be recouped or paid for costs reports still subject to reopening.

When costs are determined to be nonallowable, the rule proposes that overpayments should be recouped for cost reporting periods beginning in Federal FY1984 and any prior or subsequent cost reporting period in which similar circumstances exist.

5. States Formerly under the Medicare Waiver

Special provision is made for New York State so that it can change the state-mandated but atypical order in which it allocates administrative and general costs to the order specified in the Medicare costs report. As a result, there will also be an adjustment of direct graduate medical education costs.

6. Hospitals Electing Cost Payment for Physicians' Direct Medical and Surgical Services to Medicare Beneficiaries

The Act permits hospitals to elect payment on a reasonable cost basis for physicians' inpatient medical and surgical services to Medicare beneficiaries if they agree not to bill for charges for those services. For hospitals making that election for cost reporting periods beginning prior to October 1, 1983, both physicians' services and any resident and intern supervision incident to furnishing those services were treated separately and paid through a special payment arrangement during the base year. Since there is no documentation of the amount of time spent delivering patient services and in supervision, supervision is not reflected in the per resident amounts paid under direct GME costs but is reimbursed separately on a reasonable cost basis.

If a hospital elected reimbursement on a reasonable cost basis after Federal FY1984, costs of supervision would be included in the intern and resident cost center and therefore would be part of the calculation of the per resident amount. For these hospitals, HCFA is proposing to adjust the per resident amounts for GME to reflect proportionately lower costs.

7. End Stage Renal Disease (ESRD) Exception Criteria

While Medicare has allowed an exception to ESRD rates based on medical education costs, the exception will now be eliminated because the per resident payment approach is to be used for all GME payments and exception payments made after July 1, 1985 will be reclaimed.

8. Removal of Limit on Costs

As called for in the legislation, the regulation will remove a paragraph from a previous regulation so that the Secretary of Health and Human Services



will be prohibited from imposing limits on allowable costs of medical education other than as specifically prescribed by law.

### III. Major Issues

#### 1. Number of Residents Used in the Base Period

HCFA is proposing that a hospital include in its FTE calculation residents counted in the indirect medical education adjustment. This count includes residents funded by the Federal government, a university, or a practice plan but excludes residents in exempt units. If this proposal is adopted, the result will be that each affected hospital will arrive at an inaccurate per resident cost.

The per resident cost is derived by dividing the total costs for all residents (salary, if paid by the hospital) plus overhead for all residents regardless of whether the hospital pays their salary or stipend. The result is that the cost per resident appears to be higher than it actually is if some residents are not counted. For instance, assume a hospital has 225 residents, of whom 50 are in exempt units. To derive the per resident cost under the HCFA proposal, the hospital will add the overhead costs for all 225 residents and salary for 175 residents and divide that number by 175. As a result, cost appears higher than it actually is. Conversely, if all 225 residents are counted in the denominator the per resident cost will be too low because the numerator will contain salaries for only 175 residents. AAMC staff are currently exploring this issue with HCFA staff and will furnish supplemental information as soon as possible.

#### 2. 180 Day Appeals Period

It is critical that hospitals realize that if costs reported on the cost report have been misclassified, they have 180 days after notification of the base-period average per resident amount to present sufficient evidence to the intermediary to justify a charge. If the intermediary is satisfied that a modification to a provider's hospital-specific rate is appropriate, the rate will be modified retroactively to the provider's just cost reporting period under PPS.

If a hospital is notified that some items on its cost reports are nonallowables, the provider has 180 days to appeal the decision.

**APPENDIX I  
PROPOSED PER FTE RESIDENT UPDATES**

**I. Update for Initial Payment Year**

if the initial payment period is	then, the base period is	and base period costs per FTE resident are proposed to be updated by
7/1/85 - 6/30/86	7/1/84 - 6/30/85	1.00%
8/1/85 - 7/31/86	8/1/84 - 7/31/85	1.00
9/1/85 - 8/31/86	9/1/84 - 8/31/85	1.00
10/1/85 - 9/30/86	10/1/83 - 9/30/84	5.20%
11/1/85 - 10/31/86	11/1/83 - 10/31/84	5.03
12/1/85 - 11/30/86	12/1/83 - 11/30/84	4.95
1/1/86 - 12/31/86	1/1/84 - 12/31/84	4.57
2/1/86 - 1/31/87	2/1/84 - 1/31/85	4.52
3/1/86 - 2/28/87	3/1/84 - 2/28/85	4.74
5/1/86 - 4/30/87	5/1/84 - 4/30/85	4.75
6/1/86 - 5/31/87	6/1/84 - 5/31/85	4.73

**II. Update for all Subsequent Payment Years**

(per resident amount from prior year)      x      (increase in consumer price index)

IMMEDIATE ACTION REQUESTED

Memorandum #88-53

November 9, 1988

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

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

SUBJECT: Preparation of Comments on HCFA's Proposed Direct Medical Education Regulations

On September 21, 1988 the Health Care Financing Administration (HCFA) issued a proposed rule, "Changes in Payment Policy for Graduate Medical Education Costs" (53 Federal Register 36589) with a comment period ending November 21. In Memorandum #88-41, sent October 13, the AAMC informed its members about the major provisions in the proposed regulations. The current memorandum provides analysis of some of the more troublesome aspects of the proposed regulations and suggests information for inclusion in a comment letter that would be useful in formulating the final rule. All members are urged to comment to HCFA. Comments should be sent to Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-75-P, P.O. Box 26676, Baltimore, MD 21207. They must be received by November 21, 1988.

Two of the major issues in the regulation concern the determination of the numerator and the denominator of the formula used to derive the per resident amount (allowable costs divided by the number of residents). HCFA wants to make certain that all misclassified and nonallowable costs have been removed from the allowable cost figure (the numerator) and that the number of interns and residents are counted properly (the denominator).

A. Non-allowable and misclassified costs

In the preamble, allowable GME costs are defined to "include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center" (p. 36589). As defined in the proposed regulation, a misclassified cost is one that, if properly classified, would be considered an allowable operating cost. Examples of nonallowable costs are "the costs of a medical school related to a hospital by common ownership or control that are not directly and specifically related to patient care furnished in the hospital, and physician compensation costs that a hospital claims with respect to services furnished to individual patients that should be paid on a Part B reasonable charge basis" (p. 36592).

The AAMC believes that much confusion has been caused by HCFA'S proposal to reopen closed cost reports for the purpose of ensuring that the numerator, allowable costs, does not include any costs that would be considered either nonallowable or misclassified. The purpose of these AAMC comments is to clarify the intent of the proposed regulation. In particular, it is important to understand that the regulations allow for, and differentiate between, (1) the opening of a settled cost report to reclassify costs and arrive at the correct figure for allowable costs for use in subsequent cost reports and (2) the reopening of a settled cost report for purposes of recouping money for overpayments and repaying money for underpayments.

As proposed in the regulation, cost reports, even those that have been closed and are no longer subject to reopening under HCFA's standard rules, could be reopened for the limited purpose of correctly calculating allowable costs (1) in the GME base year, the cost reporting year beginning during the period 10/1/83 - 9/30/84, and (2) in all subsequent years. Any reopening of a permanently closed GME base year is solely for the purpose of looking at the GME costs; no other part of a cost report that is closed and settled will be reopened. While a closed cost report may be reopened for recalculation purposes, the preamble to the regulation says that overpayments will be recouped and underpayments paid only for those cost reporting periods that are currently subject to reopening. In summary, HCFA is proposing to reopen the GME base year to correct both base and subsequent years' data; however, recoupment of overpayments or supplementary payments for underpayments will only be made for years subject to reopening under normal Medicare policies.

In addition, on page 36592 (second column) the rule seems to say that if a GME reaudit produces a change in the hospital specific rate (HSR), the consequences of a changed HSR would be used to recalculate prospective payment amounts for reporting periods still subject to reopening. In your letter of comment HCFA should be asked whether this is the correct reading of the preamble language.

#### B. Counting Interns and Residents

The second part of the per resident amount formula involves the actual counting of the number of residents. In the proposed regulation HCFA seems to have considered only the simplest case - a hospital that provides salaries/stipends for all of its residents and that has no PPS exempt units. Never mentioned is how to deal with the types of arrangements that are perhaps more common, such as a hospital that has interns and residents, some of whom it funds and some of whom receive funding from a totally separate source, or a hospital that has PPS exempt units.

##### 1. Illustration of the Problem

The following two examples illustrate two of the complications not addressed by the proposed regulation.

Example 1

<u>Number of Interns/Residents</u>	<u>Salary/Stipend Paid by:</u>	<u>Where Assigned</u>
150	hospital	PPS unit
75	hospital	PPS exempt units

The first issue is whether residents who are paid by the hospital but assigned to PPS exempt units are to be included in the resident count; i.e., should the hospital shown above count 150 or 225 residents?

The preamble to the proposed regulation states that "for purposes of this rule we are proposing to use the number of residents reported on the Federal FY1984 cost report under indirect GME payment rules as the denominator in calculating base-period average per resident amounts" (p. 36593). This language suggests that HCFA would exclude residents in PPS exempt units, since that is what the indirect payment rules require. However, counted in the allowable costs of the numerator are the costs for all residents, even those in PPS exempt units. AAMC believes that the appropriate way to derive a more accurate per resident amount is to maintain consistency between the costs in the numerator and the residents in the denominator. Therefore, AAMC recommends that your comment letter asks HCFA to clarify that residents in exempt units should be included in the resident count for the purpose of computing direct medical education payments.

Example 2

<u>Number of Interns/Residents</u>	<u>Salary/Stipend Paid by:</u>	<u>Where Assigned</u>
200	hospital	PPS unit
75	other entity	PPS unit

The second major question raised by the proposed regulations is whether residents for whom the hospital does not provide a salary check but does incur other costs for supervision, teaching and overhead should be included in the resident count? This raises two questions: (1) whether a hospital must actually cut a salary check for a resident in order to be counted and (2) whether a resident compensated by another entity (e.g., medical school, practice plan, VA hospital) should be included in the count.

As to the former point, HCFA states that "we believe it appropriate not to include in a hospital's resident FTE count those residents for whom no provider participating in Medicare incurs salary/stipend and fringe benefit costs (hereinafter referred to as salary costs)" [p. 36596]. Because the language refers to "incurring a cost" the AAMC understands that HCFA's intent is to include in the count all residents for whom any Medicare participating hospital pays, whether paid through a paycheck or by reimbursing another organization. Thus residents paid through a GME consortia using hospital funds would be counted.

The question of counting residents whose stipends are paid by a non-hospital entity is more difficult to resolve. In the preamble, HCFA is clear

that it means to exclude from the resident count those residents whose stipends are fully paid by the Federal Government (p. 36596), but never addresses the issue of counting residents whose stipends may be paid by a medical school, faculty practice plan or another non-hospital entity. On the one hand, hospitals may wish to count such residents because the hospital bears supervision and teaching expenses for them. On the other hand, it is difficult to argue for including in the payment formula a person for whom the hospital or related organization does not pay the stipend. On balance, the AAMC recommends accepting HCFA's proposal to include only residents compensated by a Part A entity; however, AAMC staff welcome calls from members who disagree with this recommendation.

## 2. Recommendations for Comment Letters

Clearly, HCFA's description of which residents to count raises more questions than it settles. For HCFA to correct this deficiency, formal comments must be received which point out the confusion caused by the language and suggest more appropriate policies and/or language. Therefore, the AAMC strongly recommends that you write HCFA:

- (1) describing the problems this language creates in your hospital(s),
- (2) requesting HCFA to rewrite and clarify its proposal, and
- (3) urging HCFA to republish the clarified language as a proposed rule with an additional 60 day comment period.

Each hospital must make its own policy decision as to whether to ask for a resident count based only on hospital salaried residents or on all residents. It should be understood that the use of a smaller number of residents will raise the per resident amount and the use of a larger number of residents will lower it; however, if the number of residents used as the multiplier for the per resident amount is consistent with the count used in the denominator of that fraction, the total reimbursement amount to the hospital will be as accurate as is possible. Therefore, the AAMC recommends that comment letters stress the importance of consistency in counting so that the same counting policy is used in the GME base period and in the payment periods. This will ensure that the implementation of the regulation does not artificially decrease hospital payments.

HCFA is very interested in examples of various arrangements between hospitals and other institutions for providing and paying for interns and residents. Comment letters that include examples and also that present arguments for including or excluding specific types of residents in the resident count will be extremely useful. We believe that as HCFA becomes aware of the diversity of arrangements it will try to draft a rule, within the confines of the legislative mandate, that takes into account as many different circumstances as is reasonable.

### C. Geriatric Residencies and Fellowships

One other issue of note to some institutions is the special treatment of geriatric residency programs. As required by law, "an individual...in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish shall be treated as part of the initial residency period" for a period of not more than two years. While the proposed regulation incorporates the two-year extension for geriatric residents, it does not specify the criteria that will be used to determine which residencies and fellowship programs qualify. This is not a problem for geriatric fellowships in internal medicine and family practice where the ACGME has developed mechanisms for program approval.

For disciplines in which fellowships are not yet ACGME approved, the regulations provide no mechanism for the HHS Secretary to determine which programs to designate as approved. In this situation, some disciplines are considering asking HCFA to modify the proposed regulations to include a mechanism for HHS to designate an approved program. The Association believes the evaluation and approval of medical education programs should be left in the private sector. Therefore, the AAMC believes it is unwise to invite HHS to become involved in approving geriatric fellowship. The AAMC recommends that disciplines seeking approval of geriatric fellowships use the established ACGME mechanism for approval rather than request secretarial designation.

For more information please contact Ivy Baer, Division of Clinical Services, 202-828-0490.