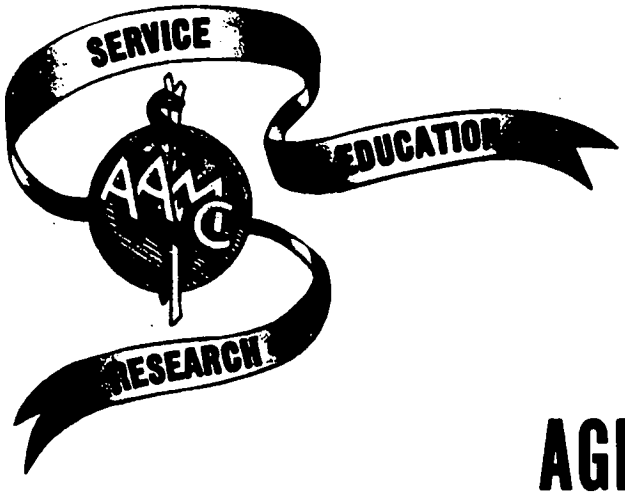

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

Friday, October 29, 1971

1:30 p.m. – 10:30 p.m.

Washington Hilton Hotel

Washington, D. C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.

COUNCIL OF ACADEMIC SOCIETIES
MEETINGS

COLLOQUIUM ON MEASURING THE EFFECTIVENESS OF PHYSICIAN PERFORMANCE

Friday, October 29
1:30 p.m. to 3:30 p.m.
Ballroom West
Washington Hilton Hotel
Washington, D. C.

Co-Sponsors

Council of Academic Societies
Conference on Research in Medical Education
Group on Student Affairs

MODERATOR: James V. Warren, M.D., Chairman of Council of Academic Societies

PARTICIPANTS: George A. Goldberg, M.D. - quality assurance in the Medicare Program

Beverly C. Payne, M.D. - statewide program of assessment of hospital ambulatory care

Sidney Shindell, M.D., Ph.D. - satisfying expectations of the physician-patient encounter

Captain James C. Waugh - criteria and assessment of pilot competence

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

AGENDA

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Friday, October 29, 1971
3:30 pm - 5:30 pm
Georgetown East

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
Meeting

February 12, 1971

Palmer House Hotel
Chicago, Illinois

MORNING SESSION

The theme of the meeting was, "The changing role of basic science in medical education." Dr. Emanuel Suter, moderator, opened the session at 9:00 a.m. Over 50 individuals were in attendance.

Twenty-minute presentations, each followed by a five-minute question period, were made by: Dr. Clifford Grobstein, "Experience at the University of California, San Diego"; Dr. Thomas Morgan, Jr., "Experience at the University of Washington"; Dr. Manfred Karnovsky, Harvard Medical School, "A basic scientist looks at his role in medical education"; and Dr. Donald Seldin, University of Texas-Southwestern, "A clinical scientist looks at the role of basic science in medical education." The session was adjourned at 12:30 p.m.

AFTERNOON SESSION

The session was devoted to "Future challenges to the CAS." CAS Chairman, Dr. James V. Warren, presided. AAMC President, Dr. John A. D. Cooper, introduced the guest speaker, Mr. Joseph S. Murtaugh, Director of the AAMC Department of Planning and Policy Development. Mr. Murtaugh chose as his topic, "National health policy planning--A choice between dilemmas." The next speaker, Dr. August G. Swanson, Director of the AAMC Department of Academic Affairs, described "Problems and prospects." Concluding this portion of the afternoon session was Dr. Sam L. Clark, Jr., CAS Chairman-Elect, who traced the history of the CAS and gave the background of the discussion draft, "Alternatives for the future."

BUSINESS MEETING

Roll Call

Dr. William B. Weil, CAS Secretary, called the roll. Of the 63 official representatives, 33 were recorded as present. Three of the 34 organizations were not represented: Academic Clinical Laboratory Physicians & Scientists, American Neurological Association, and Society of Academic Anesthesia Chairmen, Inc.

Approval of Minutes

The minutes of the meetings held October 30-31, 1970, were approved as circulated.

Alternatives for the Future

As indicated above, Dr. Clark had previously reviewed several alternatives prepared to stimulate discussion from the Membership. A number of ideas emerged:

The CAS is an embryonic organization, still growing and developing well, and should be retained; the number of representatives per organization should be increased; attempts should be made to improve attendance at meetings; better representation and communication is possible on an institutional basis rather than by societies that represent disciplines; to encourage and facilitate participation of junior faculty, representatives should be elected by the faculty council; an imbalance in representation among schools exists as reflected in the current representation from societies; the current direction of CAS should be continued but also junior faculty who are interested in curriculum, etc., could be included on an institutional basis; and agenda items should be solicited from the CAS Membership before the agenda is prepared.

ACTION: The CAS Executive Committee or a subcommittee will ponder the evolution of the CAS and present a progress report next fall.

Executive Council Report

At its Annual Business Meeting held October 31, 1970, in Los Angeles, by unanimous vote, the Membership of the Council of Academic Societies adopted the following recommendations:

1. That the Association of American Medical Colleges establish an Office of Biomedical Research within the Department of Academic Affairs. The purpose of this Office would be to attract a full-time staff to implement a biomedical research policy and to facilitate communication between the CAS and its constituent societies in matters of biomedical research.

2. That the Association of American Medical Colleges appoint a committee to study the establishment of definitions and standards for various assistants to physicians, and an accrediting mechanism for programs producing such individuals, and that such action be taken, if necessary, without participation of the AMA.

3. That the Association of American Medical Colleges establish a group for the study of the problems in the education of physicians for primary health care.

The Executive Council subsequently approved these recommendations.

In addition, the Executive Council approved applications for CAS Membership of the following 13 societies that had been recommended by the CAS Membership at the October, 1970, meeting:

1. American Academy of Allergy
2. American Academy of Ophthalmology & Otolaryngology
3. American Academy of Pediatrics
4. American Association for Thoracic Surgery
5. American College of Obstetricians and Gynecologists
6. American College of Physicians
7. American College of Surgeons
8. American Gastroenterological Association
9. American Society for Clinical Investigation, Inc.
10. Association for Academic Surgery
11. The Endocrine Society
12. Plastic Surgery Research Council
13. Society for Pediatric Research

NOTE: At its February 13, 1971, meeting, the AAMC Assembly elected the above societies to Membership.

Biomedical Research Policy Committee Report

Dr. Louis G. Welt, Chairman, described the current status of this effort.

1. At its February 11 meeting, the CAS Executive Committee accepted the Committee's final report. This report was subsequently submitted for publication in the Journal of Medical Education.

2. A draft editorial based on the Committee's survey was submitted for publication in Science.

3. Health economists are eager to show the savings to the nation (GNP) through the results of biomedical research. Funding efforts for such a study have been unsuccessful.

4. Establishment of an Office for Biomedical Research within the AAMC has been authorized.

5. President Nixon, in his State of the Union message, announced a major attack on finding the cause and a cure for cancer. Several bills have been introduced into Congress authorizing funds for cancer research and establishing administrative procedures for the expenditure of these funds. At least one of these bills (introduced by Senator Kennedy of Massachusetts and Senator Javits of New York) proposes to establish a National Cancer Authority as a separate and distinct entity from the National Institutes of Health.

Dr. Welt offered the services of the Biomedical Research Policy Committee to gather data in response to this development.

Dr. D. C. Tosteson then offered the following resolution:

> RESOLVED: The AAMC strongly endorses present legislative efforts to increase Federal support for research on the cause, diagnosis, and treatment of cancer. Cancer (along with heart disease, stroke, asthma, rheumatic fever, etc.) is a malignant killer of American citizens. Its conquest should be a goal of high national priority. However, because it represents those medical scientists who know best the complexities of this disease, the AAMC recognizes that it is only through basic research that the cause and thus the cure of cancer will be discovered. Since it is impossible to predict with certainty the fields of basic research which will yield the information necessary to control cancer, the AAMC favors a broadly based attack administered through the National Institutes of Health.

In the absence of information, Drs. Longmire and Zeman spoke against the resolution.

> ACTION: A motion, duly seconded, to table the resolution, was passed.

Dr. Tosteson subsequently amended the resolution earlier offered as follows:

> RESOLVED: The AAMC strongly endorses present efforts in the Congress to increase Federal support for research on the cause, diagnosis, and treatment of cancer. Cancer (along with heart disease, stroke, etc.) is a malignant killer and a source of great suffering of American citizens. Its conquest should be a goal of high national priority. The AAMC, because it represents those medical scientists who know the complexities of this disease, recognizes that it is only through basic research in many fields of biology and medicine that the cause and cure of cancer will be discovered. Therefore, the AAMC suggests that the administrative mechanisms to implement Federally sponsored cancer research be chosen with care. In particular, it urges that the hazards of development of a new agency be weighed against the proven competence of the National Institutes of Health in the administration of cancer and other health-related research.
>
> ACTION: The resolution was adopted (16 for and 3 against) and was forwarded to the Executive Council.
>
> NOTE: The Executive Council, after considerable discussion, drew up the following resolution, which was adopted by the AAMC Assembly on February 13 and reproduced in the Congressional Record for February 18, 1971.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
Washington, D.C., February 16, 1971.

A RESOLUTION ADOPTED BY THE ASSEMBLY OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON THE FIGHT AGAINST CANCER

Cancer is the second leading cause of death in the United States. The search for the causes and the cure of cancer, which spreads over all ages, is a scientific endeavor worthy of our greatest efforts.

New scientific leads, if fully and comprehensively exploited, may make it possible to achieve more adequate preventive and therapeutic capability for coping with this disease.

The present state of our understanding of cancer is a consequence of broad advances across the full scope of the biomedical sciences. In preparing for a greater effort, it is of the utmost importance to understand that despite the progress thus far made, the basic nature and origins of cancer are still not known. The kind of scientific formulation that permitted the development of nuclear energy and that underlies our space exploration does not exist for cancer. Further advance in fundamental biomedical sciences is essential to the solution of the unsolved problems that limit our ability to control cancer. Thus, the development of a special and extraordinary national program in cancer should be in the context of broad support of the related and underlying fields of scientific effort and in an organizational framework which assures sound direction and leadership in advancing this complex set of interrelationships.

The framework of the NIH, which had its origins with the Act of 1930, enlarged by the National Cancer Act of 1937, and the successive statutes creating the several categorical institutes in the post-war period, has made it possible to bring into being the most productive scientific community centered upon health and disease that the world has ever known. It is precisely because this organization has assured a close integration between fundamental scientific endeavor and organized attack upon specific disease problems that this extraordinary blossoming of medical science, and thus our medical capability, has taken place.

Therefore be it resolved that the Association of American Medical Colleges wholeheartedly endorses Federal support of a broad-based and intensive attack on the cancer problem called for by President Nixon in his State of the Union Message and of the magnitude envisaged in the report of the National Panel of Consultants on the Conquest of Cancer, and that this major expansion be undertaken as an integral part of the existing national framework for the advancement of biomedical knowledge for the nation's health as provided by the structure of the NIH and the National Cancer Institute.

6. Twenty-one of the 34 CAS organizations have contributed a total of $21,235 to support the activities of this Committee.

Graduate Medical Education Committee Report

Dr. Thomas D. Kinney reviewed the activities of this committee, including the CAS Conference held in the fall of 1968, and the development of the position paper, "Corporate responsibility for graduate medical education." The Committee draft of this paper dated January 8, 1971, had been distributed to the three AAMC Councils. Dr. Kinney reported the following actions of the CAS Executive Committee on February 11.

1. To revise the title of the paper to "The Implications of the Corporate REsponsibility for Graduate Medical Education": and

2. To reaffirm its approval of the document as modified on January 8, 1971, and to recommend its approval by the CAS Membership on February 12, 1971.

ACTION: Upon motion, duly seconded, the CAS Membership voted to forward the document, with appropriate modifications, to the AAMC Assembly.

Next Meeting

The CAS will next meet on the afternoon of Friday, October 29, 1971, in conjunction with the AAMC Annual Meeting, to be held at the Washington Hilton Hotel, Washington, D. C.

Adjournment

The meeting was adjourned at 5:00 p.m.

MHL/sl
5/25/71

Association of American Medical Colleges
Council of Academic Societies

Introduction

The Association of American Medical Colleges is a corporation organized for the advancement of medical education. The purpose is exclusively educational, scientific and charitable.

The Association membership consists of classes known as (1) Institutional Members, (2) Provisional Institutional Members, (3) Academic Society Members, (4) Teaching Hospital Members, and (5) such other members as provided in the Bylaws of the Association. Institutional Members have the right to vote. Provisional Institutional Members, Academic Society Members, and Teaching Hospital Members have the right to vote to the extent and in the manner provided by the Bylaws of the Association. All voting members are organizations with a tax exempt status as set forth in Section I of the Bylaws of the Association. The member Academic Societies of the Association form the Council of Academic Societies. This Council is governed by the Rules and Regulations set forth below.
The Council of Academic Societies was formed in order to provide for greater faculty participation in the affairs of the Association of American Medical Colleges. The specific objectives of the Council are to serve as a forum and as an expanded medium for communication between the Association and the faculties of the schools of medicine.

In this forum, enhanced faculty participation in the formulation of national policies to provide for the whole span of medical education is provided. Mechanisms of communication include election of representatives to serve on the Executive Council of the Association of American Medical Colleges as set forth in the Bylaws of the Association.

Rules and Regulations of the Council of Academic Societies

Section I. Members

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

2. Individuals with a special competence or interest in advancing medical education may be nominated by the Council for membership in the Association of American Medical Colleges using the same procedure as set forth above for nomi-

nation of member Societies. Individuals so elected to membership in the Association of American Medical Colleges shall be members-at-large of the Council of Academic Societies.

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

Section II. Representatives

1. The Council of Academic Societies shall consist of no more than two representatives from each member Academic Society of the Association of American Medical Colleges. These representatives shall be designated by each member Society for a term of two years; provided, however, no representatives shall serve more than four (4) consecutive terms. The Secretary shall inform each member Society one year in advance of the expiration of the term of its representatives, asking for the names of the representatives for the subsequent term.

2. Voting. Each representative of a member Academic Society shall have one (1) vote in the Council. Members-at-large shall have no vote.

Section III. Administrative Board

1. The Council of Academic Societies shall be governed by an Administrative Board which shall be composed of a Chairman, Chairman-Elect, a Secretary and six other representatives of member Academic Societies. Three of said six representatives shall be elected by written ballot at each annual meeting of the Council of Academic Societies, and each such representative shall serve for a term of two years or until his successor is elected and installed. Representatives to the Administrative Board may succeed themselves for two additional terms.

2. The Administrative Board shall meet at least twice each year at the time and place of the meetings of the Council of Academic Societies. The Administrative Board may meet at any other time and place upon call of the Chairman, provided ten (10) days written notice thereof has been given.

3. The Administrative Board shall recommend to the Nominating Committee of the Association nominees for positions on the Executive Council of the Association. The Chairman-Elect shall be one (1) nominee, and the remainder shall be chosen from members of the Administrative Board, chosen so as to present a balanced representation between societies primarily concerned with preclinical disciplines and societies primarily concerned with clinical disciplines.

4. Individuals elected as members of the Executive Council of the Association of American Medical Colleges representing the Council of Academic Societies may hold their membership in the Council of Academic Societies, ex officio, even though they may be succeeded by new representatives from their constituent organizations.

Section IV. Officers

1. The officers of the Administrative Board shall be a Chairman, a Chairman-Elect, and a Secretary, and shall be elected at the annual meeting of the Council of Academic Societies. The Chairman and Chairman-Elect shall serve for a term of one (1) year, or until their respective successors are elected and qualified. The Secretary shall serve for a term of two (2) years but may not serve for more than two (2) years following the expiration of his term as a representative of a member society. Officers shall begin their terms immediately following the annual meeting of the Council at which they are elected.

2. Duties of the Chairman. The Chairman shall be the chief administrative officer of the Council and shall preside at all meetings. He shall serve as Chairman of the Administrative Board and shall be an ex officio member of all committees. He shall have primary responsibility for arranging the agenda of meetings, conducting the business of the Council, and carrying out policies of the Council of Academic Societies determined during meetings of the Council. The Chairman shall

from time to time inform and advise officers of member academic societies of the programs and activities of the Council of Academic Societies.

3. Duties of the Chairman-Elect. The Chairman-Elect shall act as a Vice-Chairman and assume the duties of the Chairman whenever the latter is absent or unable to act. He shall be an ex officio member of all committees, except that on nominations; and he shall succeed to the office of Chairman, upon the expiration of his term as Chairman-Elect.

4. Duties of the Secretary. The Secretary shall be responsible for keeping the minutes of meetings, a roster of members, sending out notices of meetings, and informing members of the business of the Council.

Section V. Committees

1. There shall be a Nominating Committee of seven (7) members. Said Committee will be chosen by mail ballot. A ballot listing 14 representatives will be prepared by the Administrative Board and sent to all representatives to the Council. Seven (7) names shall be selected from the list by each representative and submitted to the Secretary. The seven (7) representatives receiving the largest number of votes will constitute the Nominating Committee, except that no member society shall have more than one (1) representative on the Nominating Committee.

The Committee shall meet in person and submit each year to the secretary forty-five (45) days prior to the annual meeting of the Council of Academic Societies the names of two (2) candidates for each office to be filled. The chairman of the committee will verify in advance that the nominees are willing to serve. Election of officers shall be by majority vote at the annual meeting of the Council of Academic Societies.

2. The Chairman of the Council of Academic Societies may from time to time appoint the chairmen and members of standing or ad hoc committees to advise, assist and carry out the management and operations of the Council of Academic Societies; provided, however, the Chairman shall remain responsible for all action taken by any such committee. Membership on committees will end with the expiration of the term of the representative to the Council. The Chairman of the Council of Academic Societies may appoint any representative to the Council to fill vacancies on any committee, including the Nominating Committee. Members of ad hoc committees may be selected from the academic community at large.

Section VI. Meetings

1. The Council of Academic Societies shall meet during or within two (2) days after the annual meeting of the Association of American Medical Colleges for the purpose of electing officers and transacting other business which may come before it. The Council shall meet regularly at least one

additional time each year, and it may meet for special purposes at other times determined by the Administrative Board, provided the purpose of such meetings be stated in the notice thereof. Written notice of meetings shall be given by the Secretary at least 30 days prior to the date thereof, and meetings shall be held in conjunction with other activities of the Association of American Medical Colleges whenever possible.

2. All questions before any meeting of the Council, the Administrative Board or committees shall be resolved by majority vote of those present, unless the rules and regulations of the Council or the Bylaws of the Association require otherwise.

3. The latest, revised edition of Roberts' Rules of Order shall govern the conduct of all meetings of the Council, Administrative Board, and committees wherever the Rules of Order are not inconsistent with the Council's Rules and Regulations or the Association's Bylaws.

4. Any question which five (5) or more representatives desire to have placed on the agenda of a meeting shall be considered at that meeting.

5. A quorum shall consist of 15 representatives or 25 percent (25%) of representatives to the Council, whichever is the larger.

6. The Administrative Board shall designate the member societies to be delegates to the Assembly of the Association. These member society delegates will serve for a period ending with the conclusion of the Assembly after the time of being so

nominated; provided, however, that the delegates so named shall be approved by majority vote of the Council of Academic Societies and additional nomination of delegates to the Assembly may be made at the meeting at which those named by the Administrative Board are approved.

Section VII. General Provisions

1. The Council may not incur debts or enter into commitments by accepting restricted funds or otherwise, which could in any manner become obligations of the Association of American Medical Colleges, without first obtaining specific authorization of the Executive Council or President of the Association. Member academic societies shall be responsible for costs and expenses incurred by their respective representatives to the Council of Academic Societies.

2. Any conflict between the Articles of Incorporation or the Bylaws of the Association of American Medical Colleges and these Rules and Regulations shall be resolved in accordance with the provisions of said Articles or Bylaws, as the case may be; and these Rules and Regulations shall whenever possible be applied, interpreted, or construed in a manner consistent with said Articles and Bylaws.

3. Amendments to these Rules and Regulations may be made at any meeting of the Council of Academic Societies, provided at least 30 days written notice thereof has been given to members entitled to vote by a two-thirds vote of

those voting members present. Any such amendment shall be effective only upon subsequent approval by the Executive Council.

4. Any notice required to be given to any representative or officer may be waived in writing before or after the meeting for which such notice is required.

POLICY STATEMENT ON THE RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS FOR GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education should become a responsibility of academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by academic medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment; review curricula and instructional plans for each specific program; arrange for evaluating graduate student progress periodically; and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools.

The Association urges that the Liaison Committee on Medical Education, the Residency Review Committees and the Specialty Boards establish procedures which will provide for adequate accreditation of an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.

THE IMPLICATIONS OF ACADEMIC MEDICAL CENTERS TAKING RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

A Report of a Committee of the AAMC

Thomas D. Kinney, M.D.
Leighton E. Cluff, M.D.
Charles Gregory, M.D.
William D. Holden, M.D.
Russell A. Nelson, M.D.
John I. Nurnberger, M.D.
Jonathan E. Rhoads, M.D.
William B. Weil, Jr., M.D.
Cheves McC. Smythe, M.D.
James V. Warren, M.D.

THE IMPLICATIONS OF ACADEMIC MEDICAL CENTERS TAKING RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

Introduction

During the years since the end of World War II the responsibilities of the academic medical center for all forms of clinical education and training have grown. Particularly, the education and training of postdoctoral clinical students has become one of the largest programs of these centers. Yet the relation of such programs to regulatory agencies independent of academic centers remains unchanged. Simultaneously problems of financing these programs have become much more involved. The resulting fragmentation of authority and responsibility has been deplored repeatedly. In 1965, in its report, Planning for Medical Progress Through Education, the Association of American Medical Colleges (AAMC) called for broadened university responsibility for graduate medical education (1). The American Medical Association (AMA) has also been deeply concerned with these developments. The two organizations, working in conjunction through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful reexamination of procedures for accreditation of these programs.

1. Coggeshall, L. T., Planning for Medical Progress Through Education. Evanston, Illinois: Association of American Medical Colleges, 1965.

In 1969 the AAMC published a report on The Role of the University in Graduate Medical Education, advocating less fragmentation of authority in this area and the focusing of responsibility in the university (2). Because of the major responsibility they are taking in graduate medical education, the constituent academic medical centers of the AAMC authorized this study of the implications of their responsibility for graduate medical education.

Definition

The study is directed toward the implications of the assumption by the academic center and its faculty of the classic responsibilities and authority of an academic institution for all its students and programs in medical education. This implies that the faculty would collectively assume the responsibility for the education of clinical graduate students* (interns, residents, and clinical fellows) in all departments and that the education of these students would no longer be the sole responsibility of groups of faculty oriented to individual departments or single areas of specialty practice.

Advantages

Among the advantages inherent in vesting responsibility for graduate medical education in the entire medical center

2. Smythe, C. Mc., Kinney, T. D., and Littlemeyer, M. H., The Role of the University in Graduate Medical Education. J. Med. Educ., 44: September, Special Issue, 1969.

* The use of the word "student" in this document requires definition. The individuals discussed here have received

faculty, rather than continuing departmental fragementation are the following:

1. easier implementation of the continuum concept in medical education;

2. more effective adaptation of programs to individual student's rates of progress through the educational process;

3. fostering multiple methods for conducting graduate education and thereby enhancing innovation;

4. enrichment of graduate medical education by bringing to it more of the resources of the university and its faculties;

5. promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities;

6. enhancing the principle of determination over educational programs by the individual academic centers; and

7. promotion of a comprehensive pattern of medical training and practice.

Fragmentation of Responsibility for Graduate Education

A further significant fact is that, despite oft repeated disclaimers, specialty board certification does represent a second degree and is the significant license for almost all American physicians. The evidence for this allegation is all

their doctorate and are engaged in an intensive postdoctoral program of training to become a specialist in one of the areas of medical practice. They are basically students, but usually have important commitments to medical care and teaching. They are, therefore, in some sense practicing physicians and faculty members. There is usually no degree goal, but certification by a specialty board or public acceptance of specialty status are the rewards of this training. In view of these considerations, no single word accurately describes persons in this role, and with these reservations, the word "student" will be used in this discussion.

around us but is found most importantly in the attitudes and behavior of the men in practice and of those who make hospital appointments and decide on professional reward systems, both pecuniary and nonpecuniary.

This state of affairs is a significant departure from the historical precedents for licensure to practice. In the usual formulation, civil government, because of its obligation to protect the people, grants to agencies which it controls the authority and responsibility to decide who shall be admitted to the practice of a profession. Such agencies characteristically have as their primary charge protection of the best interests of the people. In one fashion or another, through either appointment or election, in the United States they are answerable to state governments. If the specialty boards are indeed de facto licensing agencies, current practices in which they are primarily responsible to their colleagues in their specialties are far removed from usually accepted concepts of the nature of civil license.

Graduate clinical training or graduate medical education is now carried out in highly variable clinical settings; and since, clinical graduate students are frequently licensed physicians who are primarily in a learning role, the status of these students is often ambiguous. Classically, interns and residents are considered employees of hospitals, although medical schools or other professional groups may contribute to their stipends. Their status as hospital employees versus being members of the academic medical center student body or staff often leads to ambiguities.

In the majority of instances, house officers are pursuing specialty board certification or publicly ascertainable qualifications in one of the medical specialties. The duration, content, progress through training, and determination of eligibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are characteristically private, not-for-profit organizations with substantial autonomy. Academic institutions or hospitals have no direct influence on their policies or actions.

All internships are approved by the Internship Committee of the Council on Medical Education of the AMA. All residency programs are accredited by the Residency Review Committees of the AMA, with the exception of Pathology. The American Board of Pathology directly examines and accredits its residency training programs. The Residency Review Committees are made up of appointees of the specialty sections of the AMA and the appropriate boards, and many of them also have additional appointees from the appropriate Colleges or Academies. The Residency Review Committees are autonomous except for matters of policy and do not have to report back to their parent organizations for ratification of their decisions. The graduate education section of the Council on Medical Education of the AMA provides secretarial assistance and administrative support for the operation of all Residency Review Committees.

The concern of the Council on Medical Education for all facets of medical education is a matter of historical record. In the area of graduate education, however, the Council has essentially no direct authority over either the boards or the Residency Review Committees since both function independently and autonomously. However, in practice, its influence is significant. It should be noted that the AMA has its roots in the practice of medicine, and its policies will inevitably and properly always be strongly influenced by current conceptions of the interests of practicing physicians whose direct contact with education has either ended or become a secondary part of their professional activity.

The individual to whom the resident is responsible is his service chief, program director, or departmental head. Such an individual always has a major hospital appointment, and his authority over a clinical service, and hence over its residents, relates to his role in the hospital. He may or may not have a university connection of significance, ranging from major to only ceremonial. This service chief has direct responsibility for the content of the program in accord with the requirements of the specialty boards and the Residency Review Committees. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have a considerable autonomy within broad policies.

The medical school or university through its faculty members and affiliated hospitals sponsors and influences a

large segment of graduate medical education and accordingly should be considered for a more formal role in its design and operation. It has a very real authority, through its influence over hospital policies and the appointments of service chiefs, but it may or may not have real operational responsibility.

In summary, control of graduate medical education is fragmented among the following settings:

1. hospitals which employ trainees and provide the classrooms and laboratories for their education;
2. specialty boards which determine duration and a portion of the content of training and act as de facto licensing agencies;
3. Residency Review Committees which accredit on a programmatic basis;
4. service chiefs who on a programmatic basis determine the balance of content and all of the process of graduate medical education; and
5. medical schools and universities which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Attributes of Current System

Today's system has consistently and reliably produced specialists well equipped to care for the disease-related content of their areas of medical practice. In terms of its goals, it has been an acceptably-successful, pragmatic solution, adaptable to the variety of conditions found in so large and diverse a nation as the United States. These are the major strengths of this pluralistic system. If its goals, the replication of highly categorized specialists, were now

acceptable in terms of public need, its ambiguities would be tolerable.

The degree of specialization which has been brought about by advancing knowledge has resulted in the evolution of an inordinately complex structure for graduate medical education. It is this complexity which has created demands for considering a more holistic approach to the total duration and content of medical education. Assumption of responsibility for graduate medical education by the entire faculty of the academic medical center could help provide this.

Unification of Responsibility in Undergraduate Medical Education

In many ways the situation in graduate medical education today is not unlike that of undergraduate medical education 70 years ago. It is widely recognized that the medical school and its parent university have assumed responsibility for the total program of undergraduate medical education. This was the significant reform of 1890 to 1925. The issues facing graduate medical education in the 1970's contain many striking parallels and the solution being explored here has many features of that which worked so well for undergraduate medical education two generations ago.

In the 1960's medical schools began major undergraduate curricular revisions. These efforts to make undergraduate education more responsive to perceived public needs are generally based on the assumption that the undergraduate educational process is preparing students to enter into a period

of postdoctoral training. This combination of predoctoral and postdoctoral education finally produces the polished professional clinician. It now appears that the professional schools have as large a stake in the postdoctoral educational process as they have in the predoctoral.

Academic Medical Center Responsibility for Graduate Medical Education

The responsibility which would be assigned to the academic medical center faculties may be enumerated as follows:

1. determining educational objectives and goals;
2. establishing policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals;
3. appointment of faculty;
4. selecting students;
5. determining content, process and length of educational program;
6. evaluating each student's progress; and
7. designating completion of program.

These responsibilities for graduate medical education would be vested in the academic medical center, then would be delegated to its medical faculty and teaching hospitals which in turn would create a program of educational advancement protecting the rights of students while responding to the requirements of society.

The medical faculty would have a concern for creating an appropriate environment for graduate medical education. They would be responsible for selecting their fellow faculty mem-

bers and for approving the design of programs in graduate medical education, including concern for the processes used, the duration and content of learning, and the coordination and interrelation between various units of the faculty. As a faculty, they would have a voice in the selection of students, with concern for their quality and number. They would also be expected to institute procedures which would allow them to determine their students' achievement of an appropriate educational level and their readiness to take examinations for certification by the appropriate specialty boards.

Implications of the Acceptance by Academic Medical Centers of the Responsibility for Graduate Medical Education

So many agencies and people would be affected by pulling today's fragmented responsibilities together and assigning to academic medical centers both the responsibility and authority for the graduate medical education now carried out in their spheres of influence, that the only way to analyze implications of these changes is to look at the various forces involved one at a time.

The University

Administrative, financial, and organizational relations existing between parent universities and their academic medical centers would not be appreciably altered by this change. Long-range changes could be expected, and these will be touched upon in the following sections.

The Medical School Faculty

There would need to be relatively little immediate change in the day-to-day climate of the clinical faculties of medical schools. More significant would be the slow but predictable and desirable increase of interaction with other faculties in the medical center and the university at large. There would also be greater coordination of educational activity within the clinical faculty. Presumably, there would be more effective integration of various units of the medical center both medical and nonmedical, and this integration could be expected to produce different educational and patient care alignments. Possibly, the medical faculty might develop course work, a credit system and examinations similar to those now operated for undergraduate education.

These organizational patterns would likely precipitate decisions about which aspects of specialty training should precede and which should follow the M.D. degree. These questions must be faced in any event, and the recognition of medical education as a continuum--the responsibility of a single unified faculty--would be a great advantage.

The Graduate School

Assignment of responsibility to the academic medical center within a university would raise a consideration regarding the appropriateness of involvement of the graduate school. Although it is conceivable that the graduate school could be the assigned area of such programs, graduate clinical educa-

tion is so eminently the business of physicians that it makes little sense to locate it in a general university graduate school but rather to retain it in the medical center setting.

Another Degree

The issues of advanced and intermediate degrees in medicine are not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and an important piece of paper from specialty boards (certification of specialty status). The advanced clinical degree has not caught on in this country despite its trial, especially in Minnesota, and despite practices abroad. The envisioned arrangement would probably result in some formal recognition of the end of the graduate educational sequence. A degree pattern of some sort might emerge in time, probably in discoordinate fashion from school to school. As an obstacle to a new plan or organization, the degree issue need not be settled early. Any move to imperil the strength of the M.D. degree would be very strenuously resisted. The public has a firm impression of the meaning of the M.D. degree, and any change that might alter its significance should be considered with circumspection.

Hospitals

Here truly significant problems may emerge. The major educational program of a hospital would become the responsibility of an agency, in some instances external to the hospital and governed by a different board. This is a significant

shift, and it can be expected that hospitals everywhere will analyze this implication with their own interests in mind, as is only proper. The realities of getting a group of community hospitals or a community and university hospital to organize a single unified educational program will call for intensive bargaining. It can be predicted that there will be orders of difficulty, from least in a situation in which hospital and medical school are jointly owned and administered by a single board, to most where hospital ownership, operation, financing, and location are all separate. As far as financing goes, there would be few differences from today's practices. Organizationally, there might be shifts in the influence of single departments. Operationally, this might emerge as another force toward more comprehensive medical care. In terms of accreditation or approval, the hospital educational program would be approved as a unit. This would mean the number, duration, type of training, and coordination of training offered would be returned to the local control of the joint medical school-hospital faculty.

The University, Graduate Education, and Nonaffiliated Hospitals

Although the academic medical center initially would assume responsibility for the graduate education of physicians in only its affiliated hospitals, ultimately the need for the center's influence on graduate programs in nonaffiliated hospitals would be necessary for several reasons:

1. A considerable segment of all graduate education is now conducted in nonaffiliated hospitals.

2. Academic medical centers and their affiliated hospitals cannot educate effectively the total number and type of physicians required.

The relationship created might vary from one institution to another depending upon the educational capability of the nonaffiliated hospital, financial support required, and the desire of the nonaffiliated hospital to participate in an educational program designed and in large measure, directed by a faculty not totally congruous with its existing medical staff. All such arrangements for cooperative or integrated efforts would be completely voluntary and obviously to the advantage of both institutions.

The Student

At first, there would be very few changes for the people in training. However, more ready access to other departments, readier availability of the resources of other units of the medical center and the university, and better coordination of training could be expected to lead to stronger, shorter, and more varied educational programs. These would all eventually work to the advantage of the students, and this result for them must be seen as one of the major benefits expected from the change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to regular academic procedures.

Financing the Educational Component

There is obviously a cost involved in graduate medical education. For years this cost has been absorbed by residents

through deferral of earnings, by the clinical faculties through donation of their time, and by the patients, through direct charges for hospital services. This system is now challenged by everyone: the residents in their demand for higher salaries, the faculties through the emergence of the full-time system, and the patients who through large third-party payers are challenging the inclusion of any educational costs in charges to patients.

The organization of graduate clinical faculties as a whole rather than solely as departments would have no direct effect on these issues, except for their probable clarification. Expenses should not increase except as academic functions increase. The emerging acceptance of the need to fund service functions by beneficiaries of these services will shortly bring to a head responsibility for funding of the educational component of clinical graduate training. The academic medical center will be unable to assume this burden unless it in turn is financed. The general trend to spread costs of higher education widely through society by any of a number of mechanisms is seen as the only way to handle this issue.

The Specialty Boards

The role of the specialty boards would change primarily toward their becoming certifying agencies not exercising direct control over duration or content of training. This again also seems to be a change which in one form or another

is clearly on us. The boards would continue to have a major role in graduate medical education through the establishment of achievement criteria, the design and provision of examinations and the certifying of candidates who complete them successfully.

External Accrediting Agencies

The Liaison Committee on Medical Education, the Council on Medical Education of the American Medical Association, Residency Review Committees, and the Joint Commission on Hospital Accreditation are examples of external accrediting agencies. This function must be carried out in order to protect the public. One of the fundamental assumptions surrounding this proposed assumption of responsibility by academic medical centers is that in matters pertaining to accreditation, the centers would relate to a single external agency and be accredited by it. The proposed Commission on Medical Education is an effort to create such an agency at this time. Its emergence remains in doubt, but if these changes come about, the academic medical centers would need and would indeed demand the organization of a single external-accrediting and standard-maintaining body, rather than being answerable to many as they are today. The Liaison Committee on Medical Education is already taking some steps to assure greater responsibility for accreditation in graduate medical education through expanding and broadening its membership.

Patients and Consumers

No immediate effect on patients and consumers can be predicted at this time. However, since the raison d'etre of the whole health care and health education system is to serve the people, the vitality of all phases of medical education must eventually provide individuals and services for the people. Public input is desirable and has been proposed at a national level. The degree and the mechanisms for public input should be locally determined from medical center to medical center.

V A proposal to have faculty representatives from the medical schools in the CAS:

The Council of Academic Societies shall be expanded to include 2 representatives from the faculty of each institutional member of the AAMC. Said representatives should be chosen from faculty members below the rank of full professor and their selection should insure significant faculty input in the selection process. The method of selection at each institution should be made known to the Administrative Board of the CAS.

One representative should particularly represent faculty interests in biomedical research and the other in medical education and instructional innovation.

These institutional representatives shall have full voting privileges in the CAS and may serve on the Administrative Board.

The Administrative Board of the Council of Academic Societies shall be expanded by 2 members and not less than 2 positions on this Board shall be filled by faculty institutional representatives. But more than 2 may be nominated and elected.

1. Name of Society

   Southern Society for Clinical Investigation

2. Purpose

   To encourage research in the various medical sciences and to establish a forum from which new ideas can be promulgated to the medical profession.

3. Membership

   Any doctor of medicine, doctor of philosophy or doctor of science who has accomplished meritorious research in a branch of the medical sciences related to clinical medicine, and who resides within the territorial limits of the Society and enjoys an unimpeachable reputation in his profession, shall be eligible for membership.

4. Number of members

   165

5. Constitution and bylaws available

6. Minutes from 24th Annual Meeting held on 1/30/70 available

7. Organized

   1946 (as Southern Society for Clinical Research)

Completed application 8/69 ---- (8-
Revised 9/24/70

1. Name of Society

   Society of Teachers of Family Medicine

2. Purpose

   Advance medical education; develop multidisciplined instructional and scientific skills and knowledge in the field of family medicine; to provide forum for interchange of experiences and ideas; encourage research and teaching in family medicine.

3. Membership

   Any physician who holds an "academic title" and/or is engaged in the instruction of medical students or house staff...on payment of dues. Also, on any applicant not possessing the above qualifications but actively involved in the organization, teaching or promotion of family medicine on receipt of application and payment of dues.

4. Number of Members

   252

5. Constitution and Bylaws available

6. Minutes of meeting and program available

7. Organized

   October 27, 1967

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: AMERICAN FEDERATION FOR CLINICAL RESEARCH

MAILING ADDRESS: 6900 Grove Road Thorofare, New Jersey 08086

PURPOSE: See attached sheet

MEMBERSHIP CRITERIA: See attached sheet

NUMBER OF MEMBERS: 6122

DATE ORGANIZED: 1940

THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

The purpose of the organization:

> The purposes for which the corporation is organized are educational and scientific, including for such purposes the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) and contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law). In furtherance of but not to exceed the foregoing purposes, the corporation is empowered to promote and encourage original research in clinical and laboratory medicine and to welcome as members, and provide an accessible forum for, young persons engaged in such research.

Criteria for Membership:

There shall be three types of members ---

A. Regular Members
B. Senior Members
C. Corporate Members

Regular Members. Any person under the age of 41 whether a resident of the United States or not, who has completed and published a meritorious investigation in any field related to medicine shall be eligible to apply for Regular Membership.

Senior Members. Upon reaching the age of 41, A Regular Member shall automatically be transferred to Senior Membership, effective as of the first day of the calendar year following his 41st birthday. In addition, any person over the age 41 who has completed and published a meritorious investigation in any field related to medicine and who is actively stimulating younger persons to pursue similar investigations shall be eligible to apply for Senior Membership.

Corporate Members. Any corporation or foundation interested in the purposes of the AFCR may, upon invitation and the payment of the prescribed dues, become a Corporate Member of the AFCR. Such invitation shall be extended by the Secretary on the direction of the Council. The Council shall establish the classification of Corporate Membe

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: Association of Medical School Microbiology Chairmen

MAILING ADDRESS: c/o Leroy C. McLaren, Ph.D., Secretary-treasurer
Department of Microbiology
School of Medicine
The University of New Mexico
Albuquerque, New Mexico 87106

PURPOSE: To provide a forum for discussion and a medium for communication among chairmen of Departments of Microbiology or equivalent organizational units responsible for teaching medical students, in order to foster their common concerns in medical education and research.

MEMBERSHIP CRITERIA: Membership shall consist of one chairman or acting chairman of Departments of Microbiology or equivalent organizational units responsible for teaching medical students in accredited schools of medicine that hold full or provisional membership in the Association of American Medical Colleges. Any member who ceases to be chairman of a department or its equivalent as defined above shall automatically cease to be a member.

NUMBER OF MEMBERS: 96

DATE ORGANIZED: November 25, 1969

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: The American Association of Immunologists

MAILING ADDRESS: 9650 Rockville Pike
Bethesda, Maryland 20014

PURPOSE: To advance knowledge of immunology and related disciplines, and to facilitate interchange of ideas and information among the investigators in the various fields.

MEMBERSHIP CRITERIA: Candidates proposed for membership in The American Association of Immunologists are not required to have a doctorate, an equivalent amount of of training being entirely acceptable. The prinicpal requirement, while it is not possible to state or to quantitate categorically, is a genuine and active interest in the aims and purposes of the Association: research in areas of basic immunology and virology.

NUMBER OF MEMBERS: 1400

DATE ORGANIZED: 1913

VII Report of the Nominating Committee. The Council of Academic Societies Nominating Committee 1971-72 (chaired by Richard Egdahl, M.D., Boston University) has made the following nominations:

COUNCIL OF ACADEMIC SOCIETIES
Nominees for New Officers
to begin terms at
conclusion of CAS
meeting in fall 1971

BALLOTING WILL BE BY WRITTEN BALLOT AT THE COUNCIL'S BUSINESS MEETING

Chairman-Elect, CAS
One-year term (One to be elected)

William P. Longmire, Jr.

Robert G. Petersdorf

Secretary, CAS
One-year term (One to be elected)

William O. Rieke

William B. Weil, Jr.

Administrative Board
Two-year terms,
Basic Scientists (One to be elected)

George H. Acheson

Robert E. Forster

Administrative Board
Two-year terms,
Clinical Scientists (Two to be elected)

Ludwig Eichna Charles F. Gregory

Frank Moya Henry G. Schwartz

CAS nominee for election to the Executive Council of the AAMC
(One to be elected)

Ronald Estabrook

Ernst Knobil

COUNCIL OF ACADEMIC SOCIETIES

OPEN FACULTY FORUM

Friday, October 29, 1971
8:30 pm - 10:30 pm
Crystal West

The AAMC's report on the National Library of Medicine: Lister Hill Center, published in the July issue of the JOURNAL OF MEDICAL EDUCATION.

The policies of the National Internship Matching Plan.

The implications of legislation for the Conquest of Cancer.

The current state of accreditation programs for physicians assistants.

A report on the expansion of the Liaison Committee for Medical Education.