aamc

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Monday, October 23, 1978

1:30 p.m. - 5:30 p.m.

New Orleans Hilton Hotel
Ballroom A
New Orleans, Louisiana

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C. 20036

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETINGS

Monday, October 23, 1978
1:30 pm - 6:00 pm
Ballroom A
New Orleans Hilton Hotel

(Continued)

6. Report on the AAMC Graduate Medical Education Task Force--*Dr. Jack D. Myers, Chairman.* 71

7. Report on the AAMC Task Force for the Support of Medical Education--*Dr. Stuart Bondurant, Chairman*

VI. INFORMATION ITEMS:

1. Report of the Task Force on Minority Student Opportunities in Medicine *(enclosure)*

2. Report of the AAMC Task Force on Student Financing (*mailed separately; Assembly Memo #78-51)*

3. CAS Services Program 78

4. Handicapped Regulations 79

5. Current CAS Representatives 80

VII. NEW BUSINESS

5:00 p.m. Announcement of Election Results and Installation of CAS Chairman

VIII. "Institute of Medicine Report on Aging and Medical Education"

--Dr. Paul B. Beeson, Chairman, IOM Committee on the Study of the Incorporation of Knowledge About Aging in Medical Education

6:00 p.m. Adjournment

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING*

November 7, 1977

Washington Hilton Hotel
Washington, D.C.

I. Call to Order

The meeting was called to order at 1:30 p.m. Dr. A. Jay Bollet, Chairman, presided. Sixty-eight individuals, representing 53 of the 60 member societies, were present. Societies not represented were

American Association for the Study of Liver Diseases
Central Society for Clinical Nutrition
Central Society for Clinical Research
Southern Society for Clinical Investigation
American Society of Plastic & Reconstructive Surgeons
Society of Surgical Chairmen
American Urological Association

II. Approval of Minutes

The minutes of the meeting held November 12, 1976, were approved as circulated.

III. Chairman's Report - A. Jay Bollet

The full text of the Chairman's Report is attached to these minutes.

IV. President's Report - John A. D. Cooper

Dr. Cooper thanked the CAS for the tremendous contribution it had made to the AAMC over the past year. Officers and members of the CAS have been particularly willing and interested in participating in meetings with Congress and congressional staff and in presenting testimony on issues. Dr. Cooper elaborated on the efforts of the Association in the area of national policy, discussing in detail the current status of the health manpower legislation. The AAMC's successful efforts in bringing to the attention of legislators and the scientific community the potential research restraints that would have been imposed by the Recombinant DNA Re-

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*The program activities of the Association for 1977 were delineated in the AAMC Annual Report distributed to all registrants at the AAMC Annual Meeting. Additionally, a summary of these activities was prepared especially for the Council of Academic Societies (CAS) and distributed to the membership during the CAS Business Meeting. This summary was prepared at the request of CAS representatives who indicated their need for a brief reference to facilitate their reporting AAMC activities to the societies that they serve. The CAS Directory, which will be revised and distributed to the CAS mailing roster in early 1978, will contain this abstract.

search Act and the Clinical Laboratory Improvement Act were cited as an instance in which the strength of the CAS, acting in concert, was felt.

Dr. Cooper noted that this meeting marked the tenth anniversary since the founding of the Council of Academic Societies, and its membership has grown to 60 individual societies. One sign of the growing participation in the affairs of the AAMC by the membership of the Council of Academic Societies is the fact that 15 of the 60 societies now hold their regular meeting in conjunction with AAMC's annual meeting.

In an attempt to increase the participation of the CAS in the legislative and executive process in matters affecting the scientific community, during the past year CAS Public Affairs representatives met in workshops last December and June. Such great enthusiasm has been generated by the information-sharing and the ability of member societies, particularly their specially designated Public Affairs representatives, to get involved in the legislative process, that CAS interim sessions will be devoted to this format. Another meeting is planned for this coming January.

Another new program which has been established by CAS on a two-year experimental basis is the CAS service program. This activity has been designed to afford an opportunity for special service functions to be provided by the AAMC for individual societies which are in CAS membership, including maintaining membership lists, providing billing and accounting services, making arrangements for meetings and, most important, preparing newsletters, memoranda, increasing communications with the membership of the societies and increasing their participation in matters of communications with the AAMC.

V. Action Items

A. New Membership Applications

In accordance with the established procedures, election to membership in AAMC of Academic Society Members is upon recommendation by the Council of Academic Societies to the Executive Council and by majority vote in the Assembly. It was the recommendation of the CAS Administrative Board that the following applications for membership be approved by the full Council:

American Society for Clincial Pharmacology and Therapeutics
Society for Surgery of the Alimentary Tract
Society of Teachers of Emergency Medicine

ACTION: The above applications for membership were unanimously approved.

NOTE: On November 8, 1977, by action of the AAMC Assembly, these societies were elected to AAMC Membership, increasing to 63 the number of organizations in the CAS.

B. Election of Members to 1977-78 Administrative Board

ACTION: The Council elected by ballot the following to serve on the CAS Administrative Board to take office at the conclusion of the CAS Business Meeting:

Chairman-Elect

Thomas K. Oliver, Jr., M.D., Representative, Association of Medical School Pediatric Department Chairmen (Chairman, Department of Pediatrics, University of Pittsburgh)

For Administrative Board, from the Clinical Sciences (for two years, to complete the unexpired term of Dr. Eugene Braunwald)

Frank C. Wilson, Jr., M.D., Representative, American Academy of Orthopaedic Surgeons (Chairman, Division of Orthopedic Surgery, University of North Carolina)

For Administrative Board, from the Basic Sciences (for one year, to complete the unexpired term of Dr. Leslie Webster)

David M. Brown, M.D., Representative, Academy of Clinical Laboratory Physicians and Scientists (Professor, Department of Laboratory Medicine/Pathology, University of Minnesota)

For Administrative Board, from the Basic Sciences (for three years)

F. Marian Bishop, Ph.D., Representative, Society of Teachers of Family Medicine (Chairman, Department of Community Medicine, University of Alabama at Huntsville)

James B. Preston, M.D., Representative, Association of Chairmen of Departments of Physiology (Chairman, Department of Physiology, SUNY Upstate Medical Center)

Frank E. Young, M.D., Ph.D., Representative, Association of Medical School Microbiology Chairmen (Chairman, Department of Microbiology, University of Rochester)

Robert M. Berne, M.D., Representative, American Physiological Society (Chairman, Department of Physiology, University of Virginia) was installed as Chairman at the conclusion of the meeting.

C. Amendment to Rules and Regulations of CAS

Dr. Bollet reviewed the need for revision of the CAS Rules and Regulations with regard to the means for establishing the CAS Nominating Committee. As described in the agenda on page 26, instead of having the Nominating Committee elected from those present at the Annual Business Meeting, under the revised Rules and Regulations, the CAS Administrative Board would be authorized to appoint the Nominating Committee.

ACTION: On motion, duly seconded, the CAS voted unanimously to amend Section V, Paragraph 1, of the CAS Rules and Regulations, as set forth on page 26 of the agenda.

VI. Discussion Items

A. Status of Biomedical Research Legislation

Dr. Morgan reviewed the background and current status of biomedical research legislation with particular emphasis on the Clinical Laboratory Improvement Act, the recombinant DNA research bill, legislation for the support of biomedical and behavioral research, and research service awards and particular problems that relate to the taxation of stipends for research trainees.

B. Graduate Medical Education

Dr. August G. Swanson, Director of Academic Affairs, reported the following on this item.

The Directory of Accredited Residencies, 1975-76 contains a chapter on "Essentials of Approved Residencies." This is introduced by a section on "General Requirements," followed by "Special Requirements" for each specialty. The "General Requirements" have not been revised since the establishment of the Liaison Committee on Graduate Medical Education (LCGME) in 1975. A subcommittee of the LCGME was charged to draft a revision of the "General Essentials." This draft, which appeared in the meeting agenda, will be widely circulated for review and reaction in the hope that a modified document, taking into account the various points of view, will be acceptable for adoption by the five parent organizations of the LCGME probably by the fall of 1978. Comments on the draft should be forwarded to the Liaison Committee on Graduate Medical Education, 535 North Dearborn Street, Chicago, Illinois 60610.

In other developments, Dr. Swanson reported that relations between the LCGME and the Residency Review Committees (RRCs) have improved during the past year. RRC chairmen have been invited to attend LCGME meetings. An LCGME committee to assess the needs of alternate staffing for the LCGME and for the RRCs has recommended that the parent organizations renegotiate the original terms of its founding with regard to the stipulation that "for the time being" the AMA supply staff. Along with the question of separate staffing, Dr. Swanson said that the question of AMA domination of RRC sponsorship should be considered. Another item for consideration will be lessening the frequency of accreditation of programs that have no problems. All of these matters are of concern to the CAS, and Dr. Swanson urged that they be studied closely as attempts to improve the accreditation of graduate medical education continue.

Following Dr. Swanson's discussion, Dr. Ron Estabrook offered a resolution in the form of a motion. This was the following:

> RESOLVED: That the LCGME should restrict its activities to the evaluation and accreditation of the quality of the educational experience associated with graduate medical education and not be used as a vehicle to restrict the numbers or types of individuals trained for the purpose of resolving the specialty and geographic distribution of physicians.

The motion was seconded, and the following discussion ensued.

Dr. Swanson pointed out that the resolution essentially reinforced the position that the AAMC took in responding to the General Accounting Office report on this issue. The AAMC's stance was that (1) it would be appropriate for the Coordinating Council on Medical Education (CCME) to become involved in attempting to estimate the future needs of society for specialists; (2) that the CCME should not assume regulatory authority; and (3) that the LCGME should be involved in neither area.

All of these matters are of concern to the CAS, and Dr. Swanson urged that they be studied closely as attempts to improve the accreditation of graduate medical education continue.

One discussant reminded the membership that over the years the government has evinced increasing interest in improving specialty and geographic distribution. The position academic medicine has taken is that government interference is unwarranted and unwanted. The speaker felt that the motion denied the challenge to medicine to deal with these problems. For this reason, he said he would abstain from voting. Another individual agreed with that view and added that both the boards, which say their responsibility is to evaluate candidates, and the RRCs, which say their responsibility is to evaluate programs, have refused to accept this responsibility. He asked if the LCGME refused it, where would it be placed.

Dr. Swanson emphasized that the AAMC's position is that the CCME should assume the responsibility and devise approaches to estimate needs, but that the issue of regulation must be worked out in the future. AAMC's position has been that the regulatory process should be divorced from accreditation.

ACTION: The motion was passed by a voice vote.

AAMC has a Task Force on Graduate Medical Education, under the chairmanship of Dr. Jack Myers, that is charged to study graduate medical education and the problems associated with it. This task force will be studying issues surrounding accreditation and distribution. The task force report is expected in 1979, but progress reports will be offered in the interim. Much interest has been expressed by members in having representation on the task force. Those whose disciplines are not represented on the task force will have ample opportunity to participate in the working groups that will be appointed to the task force. The first working group will deal with the problems surrounding the transition from undergraduate to graduate medical education.

C. Hospital Cost Containment

Dr. James Bentley, Assistant Director, Department of Teaching Hospitals, reported on the proposed legislation on hospital cost containment. A summary of its status and an indication of its implications for

faculty appeared in the agenda on pages 55-57. Dr. Bentley said that he did not expect any action on the legislation in this session of Congress. Among the many problems, he cited in particular the difficulty of communicating to the Congress that housestaff who are seeing a patient may be learning as students and not necessarily "working" as employees. They feel that if the housestaff were not seeing patients, someone else would have to be. Also, Congress say that if housestaff are students, they want to see a clear demonstration that there is a faculty. AAMC has an ad hoc committee with representation from the Council of Academic Societies, Council of Deans, and Council of Teaching Hospitals studying the hospital cost containment bill and its impact.

VII. Information Items

A. Interim Meeting/CAS Public Affairs Representatives

This activity was described in the agenda. Forty-one societies have now appointed public affairs representatives. Dr. Morgan urged representatives of the societies that have not done so to persuade their memberships to act on this matter. Another interim meeting, scheduled for January 18, will be held at the AAMC offices in Washington, D.C. This meeting will be specifically devoted to discussion of the recommendations of the ad hoc Committee on Biomedical Research Policy.

B. CAS Services Program

The CAS Services Program was described in the agenda on pages 59-60. Ms. Kat Dolan, Staff Associate for the program, briefly discussed this activity.

C. Implementation of Capitation Provisions of Public Law 94-484

Dr. Cooper discussed this in the President's Report, particularly in regard to the U.S. foreign medical student clause. Dr. Swanson mentioned the requirement that there be a 35% primary care success rate in first-year positions in programs affiliated with medical schools and that the success rate, as determined last summer, was 52%. During the coming year, as this is reopened, he said he expects that, in an attempt to slow down subspecialty training, particularly in medicine and pediatrics, a formula may be developed by which students transferring from graduate training in primary care to go into a subspecialty in their third year may be discounted.

D. Faculty Development Progress Report

Dr. Hilliard Jason, Director, Division of Faculty Development, elaborated on the summary presented in the agenda on pages 62-63. The Faculty Development Program, now three years old, was begun with the premise that the Association wanted to explore the possibility of offering some direction to faculties in their efforts to improve their own effectiveness as teachers. Dr. Jason presented a few details of the national survey of full-time faculty who teach undergraduate medical students. One finding was that the area of largest interest among faculty members is in becoming more effective in evaluating their own performance as teachers. One of the activities on-going in this program is a self-assessment project, in which a great deal of interest has been evident among faculty.

E. New MCAT Progress Report

This report appeared in the agenda on pages 64-66. In response to a question about the problem of alleged discrimination against minority applicants in the New MCAT, Dr. Swanson indicated that this was unfounded. In the development of the New MCAT, minority educators were consulted extensively to assure the elimination of racial and cultural bias from the test. From the data available from the administration of the New MCAT in the spring, no change can be demonstrated in the range of scores of minority applicants from those of the old MCAT. The MCAT, although used by virtually every school in the admissions process, is used along with many other determinants, such as interviews, letters of recommendation, personal characteristics of the candidate, etc.

VIII. Guest Speaker

Donald Kennedy, Ph.D., Commissioner, Food and Drug Administration, spoke to the CAS on the topic, "The Food and Drug Administration and the Academic Medical Centers."

IX. Adjournment

The meeting was adjourned at 6:00 p.m.

Attachment

MHL/acm

12/13/77

REPORT OF THE CHAIRMAN
COUNCIL OF ACADEMIC SOCIETIES*

By

A. Jay Bollet, M.D.
Chairman, 1976-77

This meeting marks the beginning of the second decade of the Council of Academic Societies. Ten years ago, the CAS was founded just as the relationship between the federal government and academic medicine changed, and it must come of age, just as this relationship is evolving again.

Painful though this relationship has become, I wonder if it has changed as much as it seems? When government leaders, especially Senator Hill and Congressman Fogarty, were concerned over the need for new medical knowledge, they made research support available and bought interest in hitherto neglected fields. American academic medicine developed the strongest, most productive research program in history. This expanded research program enlarged medical school faculties and strengthened their intellectual vigor.

Subsequently, government decided the nation needed more doctors. Thanks to the enlarged research establishment, about 40 new medical schools were staffed and existing ones enlarged, so that entering classes could be increased from 8,000 to 15,000 in a single decade.

While these rapid changes were made in the nature and size of academic medicine, in response to national policies developed in relation to perceived national need, successive secretaries of Health, Education & Welfare and numerous congressmen criticized academic medicine for being

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*Presented 8 November 1977 at the Annual Business Meeting of the Council of Academic Societies, held in conjunction with the AAMC Annual Meeting, Washington Hilton Hotel, Washington, D.C.

unresponsive to public need and inadequately accountable in the use of public funds.

Changes in federal relationships to academic medicine should have evoked less surprise. The history of patronage shows that no such activity has long survived without serious interference and control by the patron.

The history of the patron in the support of academic medicine parallels the evolution of the role of the patron in the support of Renaissance art. Although the subjects of paintings were almost uniformly religious, before long the image of the patron began to appear in the paintings. Initially, the donor might appear only symbolically, as in the detail from The Way of Truth by Andrea di Firenze, about 1366. The painting was commissioned by a religious order, the Dominicans, who are represented by the hounds of God, the domini canis.

Later, the donor and his family might appear appropriately worshipful in a corner of the painting, as in the Pesaro Madonna by Titian, painted about 1520; Jacob Pesaro and his family are praying unobtrusively in the lower right corner. In other instances, the donor obviously played a much greater role in determining the composition of a similarly votive painting. For example, Jacob Meyer and his family are shown dominating The Madonna of Mercy. One wonders to what extent the patron himself must have dominated Holbein in 1526. By now, we have reached the point in which the donor's infant son is about as prominent as the Christ Child. The donor is almost as prominent as St. Mary Magdalen in the painting by the Master of Moulins.

In the painting by Jan van Eyck, the patron, Chancellor Robin of Burgundy, clearly has gained pictorial equality with the Virgin.

A later step is shown in The Votive Portrait of the Vendramin Family, who completely occupy a 1547 painting by Titian. The religious aspect

by now is limited to a crucifix in one corner, while the bulk of the painting is occupied by the donor's entire family, complete to a pet dog. What did this patron intend to venerate by his support of art?

The relationship of the patron to medical education in the U.S. has evolved similarly, from strengthening biomedical research and education, to directing biomedical research and education. In recent months, a further evolution has put the patron into an adversary relationship, producing government initiatives harmful to the health of academic medicine.

Well-known current issues of the recent past illustrate this adversary role: The manpower act which mandated admission of foreign educated students, a proposal to limit the possibility of research involving DNA, attempts to confuse the issues of ethics and consent in research, to markedly limit research that could be done on individuals unable to give their own consent, such as fetuses, infants, and even the placenta, and uninformed efforts to eliminate abuses in clinical laboratories by means that would simultaneously hamper clinical investigation.

Issues we can see ahead illustrate the new adversary relationship further. Will key congressmen become vindictive because some medical schools have taken the stand that the admissions process is not a proper subject for legislation and try to attach similar requirements to receipt of any federal funds? (Such a threat was made.)

Will postgraduate training in certain surgical fields or medical subspecialties be restricted by legislation?

Will the perceived technology gap lead to further restriction in availability of funds for basic and investigator-initiated research?

Will congress or HEW get other bright new ideas, continuing the principle that whenever problems are perceived in the health field, they should make changes in medical education?

Further ahead, we can see a decreasing number of applicants to medical school, as the size of the population in the age-group that provides the students dwindles. Will a decreasing proportion of that applicant pool opt for medicine, as the cost of a medical education rises, more of the burden of support is shifted to tuition, and the freedom of new physicians to determine their field and location of practice is restricted? Will the need to contain rising health care costs result in a decrease in service funds available to medical school faculties, while the need for such funds increases, to help offset loss of support from other sources? Will decisions by deans and hospital administrators regarding which educational programs to support be guided by which ones bring income?

As these external threats to the integrity of academic medicine increase, can the CAS adapt and become increasingly effective in representing medical school faculties on the national scene? We come to the CAS as representatives of individual disciplines, but the luxury of representing our disciplines on these issues may no longer be affordable, as our greater constituencies, the academic faculties, come into more jeopardy. Faculties can unite and present a common front when governmental intervention becomes too oppressive. Witness the recombinant DNA issue and the Health Manpower Act. Divisive issues, such as the Clinical Laboratory Improvement Act, which can be perceived as favoring one discipline over another, are dangerous when a divided voice can weaken our role and our reception on all issues by control-minded congressmen and their staffs.

In the year ahead, greater efforts will be required of society officers and CAS representatives to involve their membership in these issues, and to concern themselves with the health and quality of academic medicine as a whole. The CAS itself has initiated new programs which should help. One program consists of sessions to educate public affairs

representatives of constituent societies on these public issues. A second is the CAS services program, an experiment which can provide a closer working relationship between the CAS and member societies.

The end of the first decade of the CAS is an appropriate time to stress this theme of unity and common interest and to point to the ominous but predictable evolution in our relationship to our patrons.

ELECTION OF ACADEMIC SOCIETY MEMBERS

The following academic societies are submitted for consideration for election to membership status within the AAMC:

American Society of Hematology
American Society for Pharmacology and Experimental Therapeutics
Association of Academic Departments of Otolaryngology
Association for the Behavioral Sciences and Medical Education
Society for Neuroscience
Thoracic Surgery Program Directors

All of these societies have been recommended for membership by the CAS Administrative Board and have been forwarded to the CAS and the Assembly for approval.

BALLOT

COUNCIL OF ACADEMIC SOCIETIES
1978-79
Administrative Board

(Curriculum Vitae Forms for Candidates Appear on the Following Pages)

CHAIRMAN-ELECT

Vote For One:

Carmine D. Clemente, Ph.D., American Association of Anatomists, Los Angeles, California

Frank E. Young, M.D., Ph.D., Association of Medical School Microbiology Chairmen, Rochester, New York

ADMINISTRATIVE BOARD, BASIC SCIENCES

Vote For Two:

David M. Brown, M.D., Academy of Clinical Laboratory Physicians and Scientists, Minneapolis, Minnesota

William F. Ganong, M.D., Association of Chairmen of Departments of Physiology, San Francisco, California

H. George Mandel, M.D., Association for Medical School Pharmacology, Washington, D.C.

Robert E. Olson, M.D., Ph.D., American Society of Biological Chemists, Saint Louis, Missouri

ADMINISTRATIVE BOARD, CLINICAL SCIENCES

Vote For Two:

John B. Lynch, M.D., Educational Foundation of the American Society of Plastic and Reconstructive Surgeons, Nashville, Tennessee

Virginia V. Weldon, M.D., Society for Pediatric Research, St. Louis, Missouri

William N. Kelley, M.D., American Federation for Clinical Research, Ann Arbor, Michigan

T.R. Johns, M.D., American Neurological Association, Charlottesville, Virginia

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: David M. Brown, M.D.
Present Location (School): U. of Minnesota
CAS Society: Academy of Clinical Laboratory Physicians and Scientists
Undergraduate School: U. of Illinois-Chicago and U. of Illinois Urbana
Degree: B.S. Date 1956
Medical School: U. of Illinois-Chicago Year Graduated: 1960

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern, Rotating, U. of Illinois Research & Educ. Hospitals, 1960-61

Resident, Pediatrics, U. of Minnesota Hosp. 1961-62

Fellowship (e.g., Peds/Cardiology, Yale University, 1960-61):

Endocrinology & Metabolism, U. of Minnesota Hosp. 1962-65

Board Certification:

Pediatrics, 1966 ; Pediatric Nephrology, 1974; Spec. Comp. Clin. Path., 1976
(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

U. of Minnesota: Dir. of Clinical Labs, '71-Present; Prof. of Pediatrics, '73-Present; Prof. of Lab. Med. & Pathology, '73-Present

Act. Head, Dept. of Lab. Med., '70-71; Assoc. Prof. of Peds & Lab. Med., '70-73; Asst. Prof. of Peds & Lab. Med.,'67-70

Attend. Staff, Ped. Endocrin--Wilford Hall, USAF Hosp. San Antonio, '65-67

Societies/Affiliations:

AAMC/CAS, 1976-Present, Exec. Coun. Assoc. of Clin. Labs & Physicians, '73-75
Central Soc. for Clin. Research, Endocrine Soc., Soc. for Pediatric Research, Amer. Assn. for Advanc. of Science, Amer. Diabetes Assn., Amer. Ped. Society, Lawson-Wilkins Soc. of Pediatric Endocrinology, Orthopedic Research Soc., Amer. Physiolog. Soc., Amer. Soc. of Clin. Path., Amer. Soc. of Nephrology,

Honors/Awards:

Ph.D. Form

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Carmine D. Clemente

Present Location (School) UCLA School of Medicine

CAS Society: American Association of Anatomists

Undergraduate School: University of Pennsylvania

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

University of Pennsylvania, 1948-1950 M.S.

University of Pennsylvania, 1950-1952 Ph.D.

University College, London, 1953-1955 Postdoctoral Training

Academic Appointments (with dates)

Instructor in Anatomy, UCAL School of Medicine 1952-1953

Assistant Professor of Anatomy, UCLA School of Medicine, 1955-1959

Associate Professor of Anatomy, UCLA School of Medicine, 1959-1963

Professor and Chairman of Anatomy, UCLA School of Medicine, 1963-1973

Professor of Anatomy and Director of the Brain Research Institute, UCLA School of Medicine, 1975 to present.

Additional Appointment: Professor of Surgical Anatomy, Charles R. Drew Postgraduate Medical School, 1974 to present.

Societies/Affiliations:

American Association of Anatomists (Exec. Comm. 1969-1970; Vice Pres. 1970-1972; President 1976-1977)

American Physiological Society; National Paraplegia Foundation (Board of Directors)

American Neurological Association; Med. Research Association of California (Board of Directors)

American Academy of Neurology; Biological Stain Commissions

American Academy for Cerebral Palsy (Honorary Member)

Society for Neurosciences; International Brain Research Organization (IBRO)

Association of Anatomy Chairman (President 1971-1972)

Pavlovian Society of North America (President 1971-1972)

Southern Society of Anatomists (First Honorary Member)

Honors/Awards: Pavlov Medal & Annual Res. Award, Pavlovian Soc. of North America, 1968

Annual Award of Merit in Sci., National Paraplegia Fdn. 1973

Annual Res. Award, Japan Soc. for the Promotion of Sci., 1978

Dedication Speech, Medical School Building, University of Iowa, School of Medicine, 1973

Annual Sigma Xi Lecturer, Denison University, Granville, Ohio, 1974

Distinguished Visiting Scientist Lecturer; Medical College of Virginia, 1971

Annual Distinguished Scientist Lecture: Hahnemann Medical College and Hospital, 1977

Distinguished Scientist Lecturer: Tulane University, School of Medicine, 1974

Editor-in-Chief; EXPERIMENTAL NEUROLOGY, 1975 to present; Editor, GRAY'S ANATOMY, 1973 to present

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: William F. Ganong
Present Location (School) University of California, San Francisco
CAS Society: Association of Chairmen of Departments of Physiology
Undergraduate School: Harvard
Degree: A.B. Date: 1945
Medical School: Harvard Year Graduated: 1949

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern & Resident, Medicine, Peter Bent Brigham Hospital, Boston, 1949-51

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Fellow in Medicine & Surgery, Harvard, 1952-55

Board Certification:

(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

Asst. Professor of Physiol., University of California, San Francisco 1955-1960

Assoc. Professor of Physiol., University of California, San Francisco 1960-64

Professor of Physiology, University of California, San Francisco 1964-date

Chairman, Dept. of Physiology, University of California, San Francisco 1970-date

Societies/Affiliations:

Assoc. of Chairmen of Depts. of Physiology (President 1976-77); American Physiological Society (President 1977-78); International Society of Neuroendocrinology (Vice President 1976-80); American Society for Pharmacology and Experimental Therapeutics; US National Committee for IUPS (Chairman 1975-date); Scientific & Educational Advisory Committee for Lawrence Berkeley Lab. 1975-date; various NIH Study Sections and Task Forces; Council for High Blood Pressure Research, American Heart Association; Endocrine Society; International Brain Research Organization (IBRO); Society for Neuroscience; Society for Exp. Biol. & Med.; American Soc. of Zoologists

Honors/Awards:

IFI Award (Italy) 1970; Sherrington Soc. Lecturer, London, 1976; Starling Memorial Lecturer, Jamaica, 1978; ACDP Award for Outstanding Contributions to the Teaching of Physiology, 1978.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: T. R. Johns, II
Present Location (School) University of Virginia
CAS Society: Association University Professors of Neurology
Undergraduate School: West Virginia University; Harvard
Degree: A.B. (West Virginia University) Date: 1945
Medical School: Harvard Medical School Year Graduated: 1948

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Resident, Neurology, Jefferson, 1949-50

Resident, Neurology, Columbia-Presbyterian, 1953-55

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Research Associate and Visiting Professor, Farmakowgiska Institutionen, Lunds Universitet, Sweden

Board Certification:

Neurology, 1957 _____
(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

Associate in Neurology, Columbia, 1955.

Assistant Professor to Professor of Neurology, 1956 to present.

Head, Division of Neurology, Chairman, Department of Neurology, 1957 to present

Societies/Affiliations:

American Neurological Association, American Academy of Neurology, Association of University Professors of Neurology, Association for Research in Nervous and Mental Diseases, American Epilepsy Society, Medical Advisory Board, National Multiple Sclerosis Society, Medical Advisory Board of Myasthenia Gravis Foundation

Honors/Awards:

Phi Beta Kappa, Alpha Omega Alpha Markle Scholar in Academic Medicine, 1957-62, Columbia University College of Physicians and Surgeons 200th Anniversary Silver Medallion

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: William N. Kelley
Present Location (School) University of Michigan Medical School
CAS Society: American Federation for Clinical Research
Undergraduate School: Emory University College of Arts and Sciences
Degree: B.S. Date: 1959
Medical School: Emory University School of Medicine Year Graduated: 1963

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Parkland Memorial Hospital, Dallas, Texas 1963-65 (Internal Medicine)

Massachusetts General Hospital, Boston, Mass. 1967-68 (Internal Medicine)

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61)

NIH National Institute of Arthritis & Metabolic Disease 1965-67

Harvard Medical School 1967-68

Board Certification:

American Board of Internal Medicine - 1969
(Specialty/Date) (Specialty/Date)

Academic Appointments (With Dates):

Assistant Professor to Professor of Medicine, Duke Univ., 1968-75

Assistant Professor to Associate Professor of Biochem., Duke Univ., 1968-75

Macy Faculty Scholar, Oxford University 1974-75

Professor and Chairman, Dept. of Internal Medicine and Professor of Biological Chemistry, University of Michigan Medical School, 1975 to present.

Societies/Affiliations:

Fellow, ACP Board of Trustees, Michigan Chapter, ACP, 1975-present; ASCI Editorial Board, 1974-present; American Society of Biological Chemists Editorial Board, 1976-present; AFCR, Nat'l Council, 1971-present, President-Elect (National) 1978-79, President (National) 1979-80, Executive Committee, 1975-present; Assoc. of American Physicians; Assoc. of Professors of Medicine; American Board of Internal Medicine, 1978-present.

Honors/Awards:

Alpha Omega Alpha; Sigma Xi; John D. Lane Award, USPHS, 1969; Geigy Internat'l Prize of Rheumatology; Macy Found. Scholar Award; Board of Scientific Advisors (Consultant) NICHD, NIH, 1975; Arthritis Center Study Section, NIH, Chairman, 1978; Who's Who in America, 1978; Galens Society (honorary member), 1978; Metabolism Study Section, NIH - ad hoc member, 1976 - regular member, 1978 to present.

NOMINEES FOR CAS ADMINISTRATIVE BOARD

CV FORM

Name: John B. Lynch, M.D.
Present Location (School) Vanderbilt University
CAS Society: Ed. Found., American Soc. of Plastic and Reconstructive Surgeons
Undergraduate School: Vanderbilt University
Degree: Date:
Medical School: University of Tennessee Year Graduated: 1952

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Rotating Internship, John Gaston Hosp. 1953-54
Res., General Surg., Univ. of Texas Medical Branch, 1956-59
Res., Plastic Surgery, Univ. of Texas Medical Branch, 1959-62

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Board Certification:

General Surgery, 1962 (Specialty/Date)
Plastic Surgery, 1963
Recertified Plastic Surgery, 1978 (Specialty/Date)

Academic Appointments (With Dates):

Currently: Professor and Chairman, Dept. of Plastic and Reconstruc. Surgery, Vanderbilt Univ. Med. Ctr.; Consultant, USAF, 1968-72; Consultant, Texas State Dept. of Health, 1963-72; Consultant, St. Mary's Infirmary, 1962-72; Consultant, U.S. Public Health Service, 1967-72; Professor of Surgery (Plastic and Maxillofacial), Univ. of Texas Med. Branch, 9/72; Assoc. Professor of Surgery, (P&M) Univ. of Texas Med. Branch, 9/67; Assist. Professor of Surgery, (P&M) Univ. of Texas Med. Branch, 7/62; Instructor of Surgery (P&M), Univ. of Texas Med. Branch, 1/62.

Societies/Affiliations:

Sigma Xi; Singleton Surgical Soc. Sec-Treasurer 1968-72; AMA; Amer. Soc. of Plastic and Reconstruc. Surgeons; Amer. Assoc. of Plastic Surgeons; Fellow, Amer. Col. of Surgeons; Plastic Surg. Research Council; Amer. Cleft Palate Assoc. Amer. Burn Assoc; Soc. of Head and Neck Surgeons; Internat'l Burn Assoc.; Pan Amer. Med. Assoc.; Amer. Cancer Soc., Pres. Galveston County Chapter, 1968; Southern Med. Assoc., Post Chairman, Plastic Surg. Section, 1972-73.

~~Honors/Awards~~: Appointments:

Chancellor's Council, U. of Texas System at Austin, 1970-present; Member of Joint Forward Planning Commission for Plastic Surg. (Representing Amer. Assoc. of Plastic Surgeons) 1971-74; Member of Editorial Board, Plastic and Reconstruc. Surgery, 1974-80; Member Board of Directors of Amer. Assoc. of Plastic Surgeons, 1974-77; National Consultant in Plastic Surgery to Surgeon General, USAF, 1974 to present.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: H. George Mandel
Present Location (School) George Washington University Medical School
CAS Society: Association for Medical School Pharmacology
Undergraduate School: Yale University, B.S., Chemistry

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

Yale University, 1946-49, Ph.D., 1949, Organic Chemistry

Academic Appointments (with dates)

George Washington Univ. Medical Center, Washington, D.C., from Research Associate, 1949 to Professor 1958-; Chairman 1960-.
Commonwealth Fund Fellow, Cambridge Univ., 8 months, 1956 (biochemistry)

Commonwealth Fund Fellow, Univ. of Aukland, New Zealand, 5 months 1964 (virology)
ACS Eleanor Roosevelt Fellow, Chester Beatty Res. Inst., London, 1 year 1970-71 (cancer chemotherapy)
American Cancer Society Scholar, Univ. Calif. Med. Center, San Francisco, 1 year, 1978-79 (clinical pharmacology)

Societies/Affiliations:

American Chemical Society, 1947-; American Society of Biological Chemists, 1953-;

American Society for Pharmacology and Experimental Therapeutics, 1955-, Secretary, 1961-63, President, 1973-74.
American Association for Cancer Research 1956-; American Association for the Advancement of Science 1957-;
Association for Medical School Pharmacology, 1968-, Treasurer, 1971-73, President, 1976-78.

Honors/Awards:
John J. Abel Award in Pharmacology, 1958. Distinguished Achievement Award, Washintgon Academy of Sciences, 1958. Golden Apple Teaching Award, Student American Medical Assn., 1969. Chairman, Cancer Special Program Advisory Committe, NCI, 1976-78; Editorial Boards: J. Pharmacology and Experimental Therapeutics, 1960-65, Field Editor, 1978-; Molecular Pharmacology, 1965-69; Cancer Research, 1974-, Associate Editor, 1977-; Research Communications, 1972-.
Study Sections: NIH: Chemotherapy, Research training, NCI special program projects; American Cancer Society; VA.

Interests: Biochemical Pharmacology, Cancer Chemotherapy, Clinical Pharmacology

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Robert E. Olson, M.D., Ph.D.
Present Location (School) St. Louis University School of Medicine
CAS Society: American Society of Biological Chemists, Inc.
Undergraduate School: Gustavus Adolphus College, St. Peter, Minn.
Degree: A.B. Date: 1938
Medical School: Harvard Medical School Year Graduated: 1951

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

House Physician, Peter Bent Brigham Hospital, Boston, Mass. 1951-52., Medicine

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Ph.D., St. Louis University, 1944; Research Fellow, American Heart, Harvard School of Public Health, 1949-51; Established Investigator, Harvard School of Public Health, 1951-52.

Board Certification:

Medicine, 1965 (Specialty/Date) _____ (Specialty/Date)

Academic Appointments (With Dates):

Instructor in Biochemistry & Nutrition, Harvard School of Public Health and Harvard Medical School - 1946-47. Professor of Biochemistry & Nutrition, Head of Department, Graduate School of Public Health, U. of Pittsburgh, 1952-1965. Doisy Professor of Biochemistry and Chairman of the Dept., Professor of Medicine, St. Louis University School of Medicine, 1965-present.

Societies/Affiliations:

Amer. Assoc. for the Advancement of Science; Amer. Assoc. for Cancer Research; Amer. Board of Nutrition (Diplomate); Amer. Chemical Soc.; ACP; AFCR; Amer. Heart Assoc.; Amer. Soc. of Biological Chemists (Cas Representative, 1978-80); NBME; The Royal Soc. of Health, London, England; Internat'l Study Group for Research in Cardiac Metabolism; Alpha Omega Alpha; Sigma Xi.

Honors/Awards:

Phi Beta Kappa, St. Louis Univ., 1975; George Case Christian Scholarship, (Harvard), 1947; Soma Weiss Award and Borden Awards (Harvard), 1947; Fulbright Travel Award, 1961-62; Guggenheim (John Simon) Foundation Awards, 1961-62 and 1970-71; McCollum Award, Amer. Soc. of Clinical Nutrition, 1965; Joseph B. Goldberger Award in Clin. Nutrition, AMA, 1974; W.O. Atwater Memorial Lectureship, U.S. Dept. of Agriculture, 1978.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

NAME: Virginia V. Weldon, M. D.
Present Location (School) Washington University School of Medicine
CAS Scoiety: Society for Pediatric Research
Undergraduate School: Smith College
Degree: A.B. Date: 6/57
Medical School: Univ. of Buffalo Year Graduated: 1962

Location and Nature of Major Draduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Int. and Res., Pediatrics, Johns Hopkins 1962-1964

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Peds/Endocrinology, Johns Hopkins 1964-1967

Board Certification:

American Board of Pediatrics-1967
(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

1967-68 Instructor, Pediatrics, Johns Hopkins

1968-69 Instructor, Pediatrics, Washington University

1969-73 Asst. Prof. Pediatrics, Washington University

1973- Assoc. Prof. Pediatrics, Washington University

1975- Assistant to the Vice Chancellor for Medical Affairs, Washington University

Societies/Affiliations:

Endocrine Society (Public Affairs Committee), Society for Pediatric Research, American Pediatric Society, Pediatric Endocrine Society (Public Affairs Committee), AAAS, Midwest Society for Pediatric Research, St. Louis Medical Society

Honors/Awards:

Alpha Omega Alpha, Sigma Xi

GCRC Committee, NIH

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Frank E. Young (see also next page for M.D. information)
Present Location (School) University of Rochester
CAS Society: Association of Medical School Microbiology Chairmen
Undergraduate School: Union College

Graduate School (with degrees and areas of specialization)(e.g. University of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)

Case Western Reserve, 1959-62, Ph.D. 1962, Microbiology

Academic Appointments (with dates)

Assistant Professor, Pathology, Case Western Reserve 1962-65
Associate Member and Member, Microbiology and Experimental Pathology Scripps Clinic and Research Foundation 1965-70
Associate Professor, Biology, University of California at San Diego, 1967-70
Professor and Chairman, Department of Microbiology, University of Rochester 1970-date
Professor of Pathology, University of Rochester 1970-date
Director, Clinical Microbiology Laboratories 1970-date
Microbioligist in Chief, Strong Memorial Hospital 1976-date

Societies/Affiliations:

American Society for Microbiology
Genetics Society of America
Infectious Disease Society
American Association of Pathologists, Inc.
American Society of Biological Chemists
American Academy of Microbiology
American Association for Advancement of Science

Honors/Awards:

Alpha Omega Alpha
Faculty Research Associates American Cancer Society 1962-1970
Member Study Section Bacteriology and Mycology, USPHS; Member Microbiology Training Committee, USPHS; Member Virology and Cell Biology Study Section, American Cancer Society
Visiting Lecturer European Molecular Biology Organization 1974, 1978.
Visiting Professor, Gulbenkian Institute, 1972-1976

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Frank E. Young
Present Location (School) University of Rochester
CAS Society: Association of Medical School, Microbiology Chairmen
Undergraduate School: Union College
Degree: None Date: 1952
Medical School: State University of New York Year Graduated: 1956

Location and Nature of Major Graduate Training:

Housestaff (e.g. Inst. & Res., Pediatrics, Northwestern 1957-59):

Intern Pathology Case Western Reserve 1956-57

Resident Pathology Case Western Reserve 1957-59

Fellowship (e.g. Peds/Cardiology, Yale University, 1960-61):

Fellow, Microbiology and Pathology Case Western Reserve 1959-62

Board Certification:

Board Eligible - Pathology
(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

Assistant Professor, Pathology, Case Western Reserve 1962-65
Associate Member and Member, Microbiology and Experimental Pathology
Scripps Clinic and Research Foundation 1965-70
Associate Professor, Biology, University of California at San Diego, 1967-70
Professor and Chairman, Department of Microbiology, University of Rochester 1970-date
Professor of Pathology, University of Rochester 1970-date
Director, Clinical Microbiology Laboratories 1970-date
Microbiologist in Chief, Strong Memorial Hospital 1976-date

Societies/Affiliations:

American Society for Microbiology
Genetics Society of America
Infectious Disease Society
American Association of Pathologists, Inc.
American Society of Biological Chemists
American Academy of Microbiology
American Association for Advancement in Science

Honors/Awards:

Alpha Omega Alpha
Faculty Research Associates American Cancer Society 1962-1970
Member Study Section Bacteriology and Mycology USPHS; Member Microbiology Training Committee USPHS; Member Virology and Cell Biology Study Section, American Cancer Society
Visiting Lecturer European Molecular Biology Organization 1974, 1978.
Visiting Professor, Gulbenkian Institute, 1972-76.

AAMC DUES INCREASE

The Finance Committee Report which will be considered by the Assembly on October 24 and which appears on the following pages recommends dues increases for all categories of members during the next five years. The Committee's recommendations have been approved by the CAS Administrative Board and by the Executive Council. Approval by the Assembly is necessary for implementation.

For CAS member societies, the Committee recommended no change in the present dues structure which is based upon the number of active members in a society. The Committee did recommend that beginning in FY 1980 (July 1979) an annual inflator be applied to CAS member society dues. The inflator will be the most recent November Revised Consumer Price Index for Urban Wage Earners and Clerical Workers--Washington, D.C.

Had this policy been in effect for FY 1979 when the increase in the C.P.I. was 7.79%, CAS dues would have increased as shown below:

Less than 300 members	$ 500 to 539
300-999	$1,000 to 1,078
1,000 - 4,999	$2,000 to 2,156
5,000 +	$3,000 to 3,234

The Executive Council is empowered to reduce the inflator or to waive its application. Thus the inflator represents the outside limit on annual increases without Assembly action.

FINANCE COMMITTEE REPORT

The Association's present dues structure has been under careful review by the Finance Committee for more than two years. Working closely with both AAMC staff and the Executive Council to review program priorities and the Association's ability to meet primary membership demands, the Finance Committee analyzed income and budget projections and recommended that dues for most membership categories be increased effective in Fiscal Year 1980.

A number of factors contributed to this decision, including:

--loss of a contract with the Bureau of Health Manpower has meant that a portion of the data collection and analysis previously supported by that contract will now be continued on general funds;

--the current dues structure would not support even the minimum level of program activities endorsed by the Executive Council and would allow the Association no flexibility to respond to new initiatives and priorities as they develop;

--maintenance of adequate reserve levels was seen as necessary to protect against inflation and to provide stability for the organization and its staff.

The following table presents the complete schedule of dues as proposed by the Finance Committee and approved by the Executive Council. The inflator that is imposed on dues and service fees to keep pace with increasing costs would be subject to waiver or decrease by the Executive Council.

For the medical schools, whose dues last increased in FY 1969, the recommendation would mean that each school would pay $2,000 more in 1980 than it would have paid under the old schedule. This is because the service fee would now be calculated as a percentage of the school's total budget, rather than as a percentage of the school's budget exceeding the first $2 million. In this way, dues would be paid on an equal basis by each school while only the service fee component would be pro-rated by the size of the school's budget. Since the ceiling on the total of the dues plus service fee would be increased to $12,000, each school would pay exactly $2,000 more than it would have paid under the current schedule.

Both the basic institutional dues and the ceiling will increase slightly each of the next two years, while only the ceiling will be subject to the inflator after FY 1983. The rate applied to determine the service fee will increase by .0001 each year until a rate of .002 is achieved, at which point the rate will plateau.

For provisional institutional members (developing schools who have not enrolled their 3rd year class), the formula would apply in a similar manner. Thus, each developing school would pay up to $2,000 additional service fee in FY 1980, depending on the school's budget.

Members of the Council of Academic Societies, whose dues last increased in FY 1973, would sustain no immediate increase in dues beyond the application of the annual inflator.

Members of the Council of Teaching Hospitals, whose dues last increased in FT 1973, would pay $1,500 in FY 1980; $1,750 in FY 1981; $2,000 in FY 1982; and then become subject to the annual inflator.

The Executive Council recommends building an annual inflator into the Association's dues structure for two principal reasons. The first is to prevent inflation from gradually effecting the reduction in Association programs which would be inevitable if revenues were held constant. The second reason is to avoid the necessity of seeking Assembly approval for minor variations in dues occasioned by inflation. The inflator would be defined as the ratio of the most recent November Revised Consumer Price Index for Urban Wage Earners and Clerical Workers--Washington, D. C. Metropolitan area to that of the previous November. An inseparable part of the proposal to permit use of an annual inflator is the recommendation that the Executive Council be authorized by the Assembly to defer, reduce, or waive the scheduled increases in dues and fees for FY 1981 and all future years if, in its judgment, the full increases were not required to support the Association's authorized programs. Thus, the inflator would represent the outside limit on annual increases permissible without Assembly action.

RECOMMENDATION

The Executive Council recommends that the Report of the Finance Committee increasing dues be approved by the Assembly.

	Current Dues	FY 80	FY 81	FY 82	FY 83
Institutional					
Dues	$ 2,000	$ 2,000	$ 2,500	$ 3,000	$ 3,000
Service Fee (Proportion of School Budget)	.001	.001	.0011	.0012	.0013
Ceiling (Dues + Service Fee)	10,000	12,000	13,000	14,000	15,000+
Provisional Inst. and 2-Year Schools*	1,000	1,250	1,500	1,500+	1,500++
Affiliate Institutional	500	750	1,000	1,000+	1,000++
CAS					
Less than 300 Members	500	Apply Inflator to Present Schedule			
300 - 999	1,000	Beginning in FY 80			
1,000 - 4,999	2,000				
5,000 +	3,000				
COTH	1,000	1,500	1,750	2,000	2,000+
Corresponding	500	500+	Continue to Apply Inflator		
Individual	30	30	35	35	40
MCAT	35	35	40	40	45
AMCAS Basic Fee	20	20	20	30	30
COTRANS	20	50	50	50	50

*These schools are subject to the same services fees and ceilings as Institutional Members
+Subject to cost-of-living inflator

AAMC BIOMEDICAL AND BEHAVIORAL RESEARCH AND THE CALIFANO INITIATIVE IN SUPPORT OF U.S. HEALTH RESEARCH POLICY

For several years the AAMC Executive Council has appreciated the significant changes that have occurred and continue to occur in the goals, environment, and mechanisms of support of biomedical and behavioral research. In June 1977, the Executive Council appointed an ad hoc committee to review AAMC's existing policy and recommend needed revisions. The committee drafted a policy statement which was extensively discussed on January 18, 1978, at a special meeting of the Council of Academic Societies and revised according to suggestions received there, at a subsequent committee meeting, and during the 1978 spring meetings of the AAMC Administrative Boards, the Council of Deans, and the Executive Council (see page 33).

On June 22, 1978, the AAMC Executive Council approved the following goals and 35 specific supporting recommendations as the AAMC policy for biomedical and behavioral research.

- To emphasize that all levels of biomedical and behavioral research--basic, applied, and targeted--are necessary;
- To train a sufficient number and diversity of skilled investigators to conduct biomedical and behavioral research;
- To develop effective public involvement in the formulation of research policy;
- To strengthen the mechanisms of reviewing and coordinating research;
- To improve the structure and function of the institutions that perform research and those that support research so as to promote the orderly transfer of research findings to patient care; and
- To assure adequate support for all aspects of the research process.

As AAMC was in the final steps of developing this policy document, HEW Secretary Califano announced a new HEW effort in support of "health research." Speaking before the American Federation for Clinical Research in late April, Secretary Califano enunciated five principles as the basis of a new five-year plan for federal support of biomedical research:

- To maintain at a high level and to enhance federal support for fundamental research into biology and behavior;
- To assure that there are ample opportunities for young investigators;
- To assure that basic research is accompanied by vigorous, thoughtful interdisciplinary applications;
- To assure that government-supported research has a strong orientation toward improving the quality of the nation's health services; and

- To assure that HEW-supported research is effectively oriented to develop knowledge to support all the health missions of HEW--prevention, delivery, regulation, standard-setting, and cost control.

Califano acknowledged that "the first three principles are hardly controversial, but the two that follow, while perhaps unexceptionable in phrasing, may well be controversial in application." The dichotomy between the first three principles and the fourth and fifth principles again raises the issue of basic vs. targeted research, as Califano recognized in the conclusion of his speech: "I recognize, of course, that there is an inherent tension in the effort to produce such a plan--a tension illuminated by the contrast between the first three principles I mentioned, which are statements in support of research without any indication of the directions in which that research might go, and the last two principles, which involve a substantive orientation of our research effort." Many observers feel that the tension to which Califano refers is further heightened by his intention to accomplish all five principles without an increase in federal research funding.

As a result of the Califano speech, NIH is now involved in a comprehensive examination of the federal health research strategy. NIH Director Don Frederickson received input from most of the Institute advisory councils and conducted a discussion of Califano's five principles and the five-year research plan with them on June 15 and 16. The NIH received input from other HEW agencies such as the Food and Drug Administration, Center for Disease Control, and Alcohol, Drug Abuse, and Mental Health Administration, and synthesized this into a set of proposed HEW health planning principles. The proposed principles were presented to a national conference held at NIH on October 3-4, 1978.

Secretary Califano set the stage for the national conference by announcing that by the fall of 1979,he intends to establish a five-year budget for health research on an agency-by-agency basis. He asserted that he will stimulate public debate at every step of the budget-development process. Califano outlined the following steps that will be taken to accomplish his goal:

1. Adoption of basic principles which outline the strategy and identify potential criteria for choosing between various research priorities.

2. Set research goals for HEW agencies.

3. Translate these goals into a five-year budget which will be reviewed by the research community before it is sent to Capitol Hill.

Also at the national conference, members of the AAMC committee which drafted the AAMC policy statement presented recommendations to four of the five panels organized to receive public testimony on the DHEW Health Research Principles. Harlyn Halvorson, Brandeis University, addressed the Panel on Fundamental Research; Tom Morgan, AAMC, spoke before the Clinical Applications Panel; and Bob Berne, University of Virginia and CAS Chairman, testified before the Research Capability Panel. Theodore Cooper, Dean at Cornell, presented Unifying Concepts in Support of Research to the Panel organized for that purpose.

The substance and outcome of the October conference will be reviewed by an IOM committee, and AAMC expects to participate in this review process. Results of the conference and the review will be prepared for submission to the Secretary by January 1979. Publication of the final five-year plan for support of "health research" is scheduled for March, 1979.

A POLICY FOR BIOMEDICAL AND BEHAVIORAL RESEARCH

Prepared For

The Association of American Medical Colleges

By

Robert M. Berne, M.D., *Chairman, Council of Academic Societies; Chairman, Department of Physiology, University of Virginia School of Medicine*

Theodore Cooper, M.D., *Dean, Cornell University Medical College*

Philip R. Dodge, M.D., *Chairman, Department of Pediatrics, Washington University School of Medicine*

Harlyn Halvorson, M.D., *Director, Rosenstiel Basic Research Center, Brandeis University*

Charles Sanders, M.D., *Director, Massachusetts General Hospital*

David Skinner, M.D., *Chairman, Department of Surgery, University of Chicago/The Pritzker School of Medicine*

Samuel O. Thier, M.D., *Chairman, Department of Medicine, Yale University*

Peter C. Whybrow , M.D., *Chairman, Department of Psychiatry, Dartmouth Medical School*

Kathleen S. Dolan, *Staff Associate, AAMC Division of Biomedical Research*

Thomas E. Morgan, M.D., *Director, AAMC Division of Biomedical Research*

The AAMC policy on biomedical research was last formulated in 1971 (JME, August). In 1977 the Executive Council of the Association appreciated the fact that significant changes had occurred and continue to occur in the goals, environment and mechanisms of support of biomedical and behavioral research. In June, 1977, the Executive Council appointed an ad hoc committee to review its existing policy and to recommend needed revisons. The committee drafted a policy statement which was extensively discussed on January 18, 1978, at a special meeting of the Council of Academic Societies and revised according to suggestions received there, at a subsequent committee meeting, and during the 1978 Spring meetings of the Administrative Boards, Council of Deans, and Executive Council.

On June 22, 1978, the Executive Council of the Association of American Medical Colleges approved the following goals and recommendations as the AAMC policy for biomedical and behavioral research:

GOAL 1: Emphasize that all levels of biomedical and behavioral research, including basic, applied, and targeted, are necessary.

GOAL 2: Train a sufficient number and diversity of skilled investigators to conduct biomedical and behavioral research.

GOAL 3: Develop effective public involvement in the formulation of research policy.

GOAL 4: Strengthen the mechanisms of reviewing and coordinating research.

GOAL 5: Improve the structure and function of the institutions which perform research and those which support research so as to promote the orderly transfer of research findings to patient care.

GOAL 6: Assure adequate support for all aspects of the research process.

GOAL 1: EMPHASIZE THAT ALL LEVELS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, INCLUDING BASIC, APPLIED AND TARGETED, ARE NECESSARY.

The crucial medical problem among the many health issues of this Nation is the continued existence of incapacitating or fatal diseases for which there is presently neither adequate treatment nor mechanisms for prevention or cure. The American people acknowledge that research in the biomedical and behavioral sciences offers the best hope of solving this medical problem by their substantial and continued investment in biomedical research since the end of the second World War. This consistent national commitment has already resulted in the rapid advance of biomedical sciences, the acquisition of much new medical knowledge, and improved diagnosis, treatment, and prevention of many diseases.

One of the most important challenges facing the biomedical and behavioral research community at the present time is determining the appropriate balance between exploratory research on the one hand and the understandable desire of the Congress and the public to accelerate the transfer of ideas gained from research to the care of the sick and the conquest of disease on the other hand. Three broad categories of research may be distinguished, each valuable in its own right and each deserving of continued support.

Basic Research: The first type is basic research which is exploratory, usually long term and undifferentiated, and is rarely targeted, programmed or centrally directed. It depends on investigator-initiated ideas and its practical application is often unpredictable. Nevertheless, basic research is essential to the development of new fundamental knowledge upon which applied research and development are based. Historically the application of

knowledge from basic research to practical problems of health has proved the importance of this position. There are numerous examples of the value of basic research in the solution of key health problems and some of these have been clearly described by Drs. Comroe and Dripps.*

It cannot be emphasized too strongly that the discovery of new fundamental knowledge through basic research remains the foundation for progress in the understanding of disease processes and their ultimate prevention and/or cure. Basic research is the critical first step in this process and, in the short term, the effectiveness of targeted programs depends strongly on basic research. Despite the great scientific progress of the last 20 years there remain demonstrable gaps in knowledge and areas of ignorance. For this reason basic research must be awarded a high priority.

Applied Research: Applied research in the biomedical and behavioral sciences starts from basic principles of biology and uses them to investigate human problems. Applied research is essential to a balanced research effort. Not only do many discoveries of basic biomedical science find application to human disease through applied research, but also many stimuli to basic research originate in the investigation of clinical problems. Clearly, the prepared investigative mind that follows clinical leads assures progress in the understanding, treatment and prevention of disease.

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* Circulation Research, 35: 661-669, 1974

Applied research may be performed by either basic scientists or clinicians just as basic research may be performed by either. However, the demonstration of the applicability, safety and reliability of basic research findings to clinical situations remains the province of clinician-scientists. Such scientists also guide and inspire basic scientists in the elucidation of human disease processes.

Targeted Research: For many years basic and applied research have been initiated primarily by the investigator, and Federal support of this research has been generally organized along disease or organ system-oriented program lines in the Institutes of the National Institutes of Health. The systemic, disease-oriented programs of these Institutes enjoy the wholehearted support of the Congress which, in turn, views such programs as the best hope for the generation of new research discoveries and their application to national health goals. The result of this Congressional enthusiasm has been the creation of legislative authorities targeted on specific disease. More recently other authorities have mandated clinical trials, research and demonstration centers, and disease-oriented programs on an unprecedented scale. The new authorities for the National Cancer Institute, for the National Heart, Lung and Blood Institute and, to a lesser extent, for programs such as Arthritis and Diabetes are examples. These legislative authorities have been to a large extent through targeted research programs using a combination of research contracts and center grants. Such targeted research has caused tension and competed disproportionately for funding with basic and applied research initiated by investigators.

The trend to establish research and demonstration centers targeted on specific diseases has had yet another effect - that of requiring both NIH and the performer institutions to plan demonstration projects to an unprecedented degree. Demonstration programs are not new either to the academic medical centers or the Public Health Service but their uneven record over the last two decades suggests the need for a more thorough and objective assessment of past failures and successes before any further expansion. The establishment of demonstration programs frequently has not been preceded by a careful analysis of such essential factors as the state of scientific knowledge, the identification of target populations and the adequacy of trained manpower and other necessary resources. These programs have also posed difficult problems within the academic medical centers and NIH where the managerial talents peculiarly required for these specialized functions were not available, despite the array of scientific talent in those institutions.

All of these changes have created undesirable competition for program funding priorities among basic, applied and targeted research. Targeted research in general and research and demonstration centers in particular have had a negative effect on the priority given to fundamental research. The AAMC believes that the Congress, the Administration and the research community should clearly enunciate and periodically reaffirm a commitment to each of these types of interrelated research.

Recommendation 1: The Federal establishment as the principal provider of research funds should recognize the need to assure stability and an appropriate balance among basic, applied and targeted research.

GOAL 2: TRAIN A SUFFICIENT NUMBER AND DIVERSITY OF SKILLED INVESTIGATORS TO CONDUCT BIOMEDICAL AND BEHAVIORAL RESEARCH.

The growth and maturation of biomedical research in the United States would not have been possible without strong Federal support of biomedical and behavioral research and the training of the manpower necessary to exploit research opportunities. Both of these functions must be interwoven if the effort to improve our biomedical and behavioral knowledge is to advance. The conduct of programs of sophisticated research on major diseases requires highly trained biomedical and behavioral scientists with a wide range of abilities extending from competence in the basic sciences to skills in applied clinical research. To meet this manpower need, the Federal government has developed training programs to ensure the continued availability of highly skilled scientists to meet national research objectives.

It is important to distinguish three categories of training of research personnel - Ph.D.'s, M.D.'s, and M.D.-Ph.D.'s - because each category has separate attributes, requirements, and problems. Each has merit and the first two categories are not interchangeable.

Training of Ph.D.'s - The first exposure of Ph.D.'s to research occurs at the pre-doctoral level. Experience has shown that the most appropriate mechanism for the first exposure is the institutional training grant. The institutional training grant has four significant advantages. First, it permits selection of trainees at the institutional level where the most appropriate match can be made between training capabilities and the individual's talents and aspirations for a research career. Second, the training grant is dedicated to sustain high quality of the training environ-

ment and can be carefully monitored by training grant study sections of the NIH. Third, it stimulates the integration of diverse components necessary to achieve the specific training goals. Fourth, it provides sufficient lead time so that the trainee is not faced with the uncertainty of support at a time when it is too late to seek an alternative position. Although the institutional training grant is also of value for the training of the post-doctoral Ph.D., the individual fellowship award may be more appropriate for the post-doctoral training of Ph.D.'s in research since such individuals are likely to have already established a record for themselves in research and are able to compete nationally for such awards.

Matching the supply and need for researchers continues to be a difficult problem. Although in some areas the number of basic research scientists being trained presently exceeds the need, some other basic science areas (such as anatomy) continue to experience shortages. Information, sometimes conflicting, on the need for training is available from many sources. Therefore, great care and forethought are necessary before adjustments in the supply of trained scientists are undertaken. A reduction in training support signals clearly to students that the climate of research is changing and even if support is re-established trainees may be wary of embarking on a career in research.

The discouragment of interested students and the time lag involved in reversing the trend of training curtailment and in "catching up" may lead to a serious dearth of manpower such as occurred in the case of post-war physical science doctorates. Actually, a slight excess of trainees over jobs is necessary to assure enough high quality investigators in training,

to cover losses by attrition, and to protect against the inadequacies of manpower projections. If a reduction of the number of trainees is necessary, it is important to preserve the quality of those being trained by not terminating training programs indiscriminately, and by considering methods of redirecting these scientists into areas of need. One such method is that of interdisciplinary training which has considerable merit because of the demonstrated ability of such Ph.D.'s to switch fields of research activity as new opportunities develop. However, rigorous disciplinary training programs should remain the mainstay of Ph.D. training.

Training of M.D.'s - In contrast to Ph.D. training the first experience of M.D.'s in research usually occurs at the post-doctoral level. Here, again, the most appropriate training mechanism for the initial research exposure is the institutional training grant. Potential physician-scientists are particularly susceptible to being dissuaded from pursuing their research interests if their mentors are not able to provide a planned program for their development. Institutional training grants provide this opportunity. Experience since 1974 demonstrates that the vagaries of applying for an individual fellowship are a major discouragement to potential clinician-investigators who are always susceptible to the greater immediate monetary rewards of private practice. Individual fellowships are appropriate for more mature investigators who have been prepared under the auspices of institutional training grants. The individual research fellowship is appropriate for special situations, for further training of research experienced physicians, or for those situations where a single trainee works with a single, excellent scientist. The current expansion of the knowledge

transfer process in clinical areas is dependent upon physician investigators and requires the training of an adequate supply of physician-scientists. In contrast to Ph.D.'s, attrition for M.D.'s entering research will always be greater because more alternate career possibilities exist for M.D.'s. This difference should be taken into account in establishing clinical research training programs.

The research training process is particularly crucial in the case of physicians in a situation where the inducements and pressures for medical practice, among other influences, create a highly sensitive career decision. A number of additive factors are at work:

1) Some clinical research manpower shortage areas are being addressed by special initiatives (e.g. immunology, pulmonary diseases) but no special programs have been instituted in other documented shortage areas in biomedical and behavioral research.

2) Present NIH regulations do not permit training programs to provide an adequate mix of clinical and research experiences appropriate for physician research trainees.

3) Potential trainees are discouraged by stipends that fall below those of residents at the same level of training.

4) The low percentage of research grants that are funded in clinical areas fosters a perception among young investigators that they will be unable to follow a career in research.

5) Although the data are not yet clear, the payback provision instituted in 1974 also may have discouraged potential research trainees.

6) The inconstancy of Federal support for training after 1974 and the asynchrony of Federal training announcements with academic trainees' decisions have made research training even less attractive.

These factors have reduced the number of training applications to the point in 1976 where only 60% of the recommended Federal training positions in

clinical sciences were filled. As a result, the supply of medical scientists has been jeopardized, not only in applied research but also in the increased activities of targeted programs such as clinical trials, research and demonstration centers and drug and medical device evaluation.

Research training programs for clinical investigators must be designed to provide concentrated, comprehensive educational training in research. The acquisition of clinical skills should be clearly secondary and necessary to the goals of the research training. This clear emphasis on research as distinguished from training for the practice of a specialty or subspecialty should increase the effectiveness of federally supported research training programs.

The AAMC recognizes that in the past a significant number of individuals who received research training from federally funded programs have gone directly into clinical practice. The payback provisions set forth in the National Research Service Award Act of 1974 were instituted to discourage this practice. The AAMC finds that this requirement may now be a deterrent to the recruitment of young clinical investigators. The effect of payback and other factors on the development of needed clinical research talent should be studied and, if necessary, alternatives should be proposed. For example, rather than penalizing individual students through a rigid payback formula the performance of each institutional training grant program could be more carefully scrutinized and those which are not fulfilling expectations for producing dedicated career investigators could be terminated. This evaluation, combined with deliberate emphasis on acquiring research skills as opposed to clinical skills, should make a payback requirement unnecessary.

The payback provision also fails to take into account the fact that while both M.D.'s and Ph.D's are receiving training they are performing research. This research is generally of high quality and is always obtained at a lower cost than that produced by the same researcher after completion of the training.

Training of M.D. - Ph.D.'s - For about 10 years the NIH has supported the training of a small number of extremely well-qualified individuals in a formal program leading to the combined M.D. - Ph.D. This Medical Scientist Training Program is just now reaching maturity but is producing a high yield of excellent scientists with broad competence. The Program can be expanded cautiously and still maintain its excellent standards. The trainees fill a real need in the study of basic problems and the Program certainly deserves continued support.

Current legislation limits the length of time an individual can be supported under the National Research Service Awards Act (NRSA) to three years. In certain instances, particularly when an individual seeks research training at both the pre-doctoral and post-doctoral levels, this is insufficient. The time period should be extended preferably by legislation or through adoption of a liberal waiver policy.

Recommendation 2

a) The Federal government should renew its commitment to both pre- and post-doctoral training of highly qualified research scientists in the biomedical and behavioral sciences.

b) The institutional training grants should be recognized as the most appropriate mechanism to provide initial research experiences in either basic or clinical areas.

c) Methods should be found to encourage research training and academic careers by physician scientists.

d) The possible impact of the payback requirement on reducing the number of clinical science trainees should be examined and other alternatives sought if necessary.

e) The Medical Scientist Training Program should be continued and expanded cautiously.

f) The limitation on the length of time an individual can be supported under NRSA should be extended.

g) Stipend levels should be increased so as to be commensurate with other trainee stipends at the same educational level.

GOAL 3: DEVELOP EFFECTIVE PUBLIC INVOLVEMENT IN THE FORMULATION OF RESEARCH POLICY.

The public has come to have high expectations for improvements in health as a result of its unflagging support of biomedical and behavioral research over the past 30 years. In part these high expectations have resulted in an understandable desire for more accountability in the biomedical research field but it is often difficult to provide proof of a reasonable return on the research effort.

There continues to be a need to provide information to the public about the nature of scientific research, the accomplishments that can be reasonably expected and the limitations of science. The AAMC and its constituents recognize the need to participate in public education campaigns to a much greater degree than in the past. This would stimulate greater public discussion of the allocation of funds to various fields of research, emphasize appropriate goals for research, and ensure a better understanding of the costs and benefits of expected gains.

Public participation is not appropriate in the highly technical review of specific applications by initial review groups (study sections) or in decision making about specific research projects. However, the appointment of public members to the advisory councils of the separate Institutes, to program development panels, and to the NIH Director's Advisory Council is a desirable way to involve the public in the formulation of research policy. To make public participation more effective, public members should be selected for their interest and abilities rather than for their political affiliation. Properly constituted advisory councils are an excellent public forum for the discussion

of research strategy and other public policy matters. The advisory councils should have more effective representation of the public and be more active in assessing areas needing more or less research emphasis or areas in which demonstration programs are likely to be effective. Means should be sought to assure the education of the public about the advances of biomedical research and the reasonably expected benefits of such research as well as potential, real, or imagined hazards that can arise from research. In these ways public opinion can be informed and mobilized on the important questions of research policy and strategy, such as the balance between basic and applied research and the evaluation of the continuum by which new knowledge is applied to solving practical health problems.

Recommendation 3 — The biomedical and behavioral research community should encourage efforts to increase public understanding and support of biomedical and behavioral research policy. The advisory council apparatus of the NIH and ADAMHA should be strengthened to assist in this objective. Scientists must assume a responsibility to assist the public in setting realistic goals and time tables for research efforts.

GOAL 4: STRENGTHEN THE MECHANISMS OF REVIEWING AND COORDINATING RESEARCH.

The continued assurance of the quality of biomedical research depends to a large degree on the NIH peer review process. While the peer review concept as developed at the NIH has had unparalleled success in assuring the allocation of funds to the best possible research, a number of concerns have been voiced about the scientific peer review system in general. The NIH system has been scrutinized extensively by the President's Biomedical Research Panel, by the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and by a committee appointed by the NIH Director. The NIH committee has recommended changes that would improve the system. Each of these groups recommends statutory exemptions to permit the continued closure of peer review sessions. Such closure protects the confidentiality of the peer evaluation and assures frank, uninhibited, and therefore, the most searching, critique of research protocols. The AAMC agrees that the Public Health Service Act should be modified to permit closure of study section and council meetings during review of individual research applications and when qualifications of individual scientists are discussed. Patent and proprietary rights of investigators would be protected by such modification and premature disclosure of clinical trials and similar data prevented. The AAMC has repeatedly urged such an amendment to the Public Health Service Act to modify the deleterious effects of the Freedom of Information and the Federal Advisory Committee Act on the peer review process and the conduct of clinical trials. Meetings would be open to the public in all other circumstances. In turn, biomedical and behavioral scientists must be alert to their responsibilities in several areas including provision of

sufficient information to NIH or other designated agencies for project evaluation and revelation of evidence of potential health hazards.

Although the peer review system has been successful in identifying meritorious research for Federal support, it should be clearly and candidly recognized that not all supported research eventually is equally productive or meets its stated objective. Stringent evaluation of research projects is necessary and nonproductive or lower quality research must be phased out so that funds can be allocated to more fruitful projects. The criticism has been made that not all of the components of large, multiproject grants and contracts are as carefully scrutinized as are individual grant proposals and this leads to funding less-promising research. This criticism must be carefully considered and corrective measures taken when indicated. It is important to tighten the peer review requirements, particularly in the case of large categorical centers, specialized centers of research, program projects and research contracts, so that sharp, competitive review of such programs is assured.

The number of applications has greatly increased, contributing to a greater workload for the study sections, a less thorough review of all applications, and a lengthening of the application process. The NIH should establish administrative mechanisms to decrease the burdens on study sections and expedite the application process.

Recommendation 4 a) The Public Health Service Act should be modified to permit confidential, closed panel peer review of grant and contract applications so as to obtain high quality reviews of proposals, to prevent invasion of privacy of the applicants, to safeguard clinical trials, and to protect proprietary interests.

b) The scientific community through its representatives in the peer review system must assume responsibility for critical evaluation of all research projects particulary those included in multiproject grants or contracts, so that lower quality research is not funded and funds are allocated to the most promising avenues of research.

c) The cause and effect of work load increases and other deleterious influences on the peer-review system should be carefully monitored and appropriate corrective action taken.

GOAL 5: IMPROVE THE STRUCTURE AND FUNCTION OF THE INSTITUTIONS WHICH PERFORM RESEARCH AND THOSE WHICH SUPPORT RESEARCH SO AS TO PROMOTE THE ORDERLY TRANSFER OF RESEARCH FINDINGS TO PATIENT CARE.

Changes in the Management of the Federal Research Endeavor: The Federal share of the support of biomedical and behavioral research is a major and irreplaceable part of the total effort. However, certain changes are needed to improve the administration of the Federal share of that effort.

The AAMC has repeatedly stressed the desirability of strengthening the authority of the NIH Director. Among the recommendations have been the lessening of political influences in the appointment and term of the Director. Although these remain important considerations, there are other changes in the authority of the NIH Director which are now more urgent. The AAMC believes that the Director should have available a small fund to allocate to promising programs at his discretion but with the assistance of an appropriate advisory apparatus. It is also advisable to re-establish the authority of the Director over the programs of the National Cancer Institute. The separation of the National Cancer Institute from the remainder of NIH and the creation of the President's Cancer Panel in response to special interests has assured that the cancer effort is now well established. It is now possible to return this research authority to the NIH Director and to assure this sound concept of science management for the future. The combination of this move with the strengthening of the NIH advisory council structure would achieve a significant improvement in programmatic and scientific coordination.

Although the research programs of ADAMHA, particularly of the National Institute of Mental Health, have been in large part neglected as the agency

turned its attention to mental health service programs, the AAMC believes that with new leadership an opportunity now exists to effect substantial contributions in behavioral research. For this reason the AAMC does not recommend that NIMH be placed under the auspices of the NIH at this time. A continuing review will be conducted and the AAMC may, in the future, favor such unification if ADAMHA's research functions continue to be obscured by service commitments.

The role of the advisory councils in the work of NIH and ADAMHA should be strengthened. The councils are uniquely able to assess regularly and thoroughly the overall status of research programs within the various Institutes and the NIH and ADAMHA. A primary function of the advisory councils of NIH and ADAMHA should be the assessment of areas which need additional research emphasis and the identification of those areas which justify increased financial support. These same councils should provide input and advice on research funding and should identify those areas which lag in the application of basic research findings to clinical practice. Such an assessment would make overall research strategy development more apparent and unified. The advisory councils should be appointed without undue delays and should be protected from political intervention in the selection of council members. The advice of Institute directors should be given greater weight in the appointment of professional members.

Problems continue to surround the initiation and management of multidisciplinary and research/demonstration centers and large program project grants. As a

matter of public policy the broad criteria for the employment and evaluation of such programs should be set out by the Director, NIH, with advice from his advisory committee. This policy can then serve as a guide to the various Institutes and prevent fragmentation, unnecessary competition, conflicting guidelines, and overlapping functions. In a similar way policies for starting new programs or terminating others should be developed by the Director.

Recommendations 5

a) Efforts should be made to strengthen the effectiveness of the Director, NIH by creating a special director's fund.

b) The programs of the National Cancer Institute should be placed under the authority of the Director of the National Institutes of Health. The research programs of ADAMHA should be carefully monitored with a view to placing them in NIH should they fail to prosper in ADAMHA.

c) The NIH and ADAMHA advisory councils should have a greater role in establishing a balance among research activities.

d) The advisory councils should be protected from political intervention.

e) The Director, NIH, assisted by his advisory committee should establish criteria for the initiation and evaluation of centers and other broad programs.

Promotion of Knowledge Transfer: In 1976 the President's Biomedical Research Panel described the following continuum of activities in the research, technology transfer and application process:

"1. discovery, through research, of new knowledge and the relating of new knowledge to the existing base;

2. translation of new knowledge, through applied research, into new technology and strategy for movement of discovery into health care;

3. validation of new technology through clinical trials;

4. determination of the safety and efficacy of new technology for widespread dissemination through demonstration projects;

5. education of the professional community in the proper use of the new technology and of the lay community in the nature of these developments; and;

6. skillful and balanced application of the new developments to the population". [1]

Research directed toward the discovery of new knowledge, its application to medical or health care and of determining the validity, safety and efficacy of new technology is very important (steps 1-4). Such targeted research merges with demonstration and dissemination of proved technologies as part of the process of technology transfer (step 4). These latter transfer activities are expensive in terms of time, money and personnel and they are difficult to devise and control. Although support of biomedical research is the primary mission of the NIH there has been a tendency during the past five years to expect NIH to assume these additional technology transfer responsibilities for lack of a more appropriate organizational alternative.

The transfer of biomedical and behavioral knowledge technology is a multi-faceted activity which includes 1) reduction of basic knowledge to practical application, 2) development of techniques, drugs and procedures and 3) invention of devices and treatment interventions. The AAMC holds that this transfer is so complex and broad in scope that responsibility for it should be shared within the biomedical research community by private agencies, by

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[1] Report of the President's Biomedical Research Panel, page 7 (1976).

public agencies (including but not limited to the NIH) and by industry. The transfer of research advances to clinical care is the area which is the most complex, least understood, and most expensive. The uncoordinated nature of current activities in this area requires new approaches, but the number and complexity of activities and the inter-relationships between research, testing, demonstration and practice are such that no single Federal agency can assume the entire burden.

In 1976 the AAMC recommended that NIH activities should include basic and applied research, clinical trials and initial evaluation of the safety and efficacy of new technology within the complex context of social and economic reality. The further validation of safety and efficacy beyond an initial determination is not properly a NIH function and historically has been much better accomplished by the private sector. Further, the AAMC held that the widespread dissemination of new technology through demonstration projects is the responsibility of a health service agency rather than that of a biomedical research agency. To add service requirements to a research agency is unwise; widespread demonstration and health care delivery projects impose almost insatiable demands on the energies and resources of any agency. The experience of the National Institute of Mental Health is instructive because that Institute became so committed to large scale service programs that its research programs suffered.

Primary responsibility for technology transfer should not be assigned to the NIH simply because NIH has performed its research mission so well. A more rational response would be for NIH to exert leadership in the initiation

and promotion of technology transfer. NIH should exercise its judgment in areas where it has the necessary expertise and capacity to select research-proven areas for further clinical testing by other agencies. NIH should lead in seeing that such projects are undertaken but should not itself test, disseminate or educate where such activities would compromise its ability to perform its basic research mission. NIH should participate in the planning and evaluation of those demonstration projects which require its leadership and expertise, sharing this responsibility with other public agencies, the biomedical research community and professional groups. Widespread dissemination through demonstration projects, determination of cost effectiveness, professional and lay education, and widespread application of new technology are functions which can be accomplished better by the private sector or by other Federal agencies competent in education, management or regulation.

As specific examples, it would be an appropriate function of the National Center for Health Services Research to examine the cost effectiveness of a new technology, of the Food and Drug Administration to answer questions about the safety and efficacy of drugs and devices, and of the Center for Disease Control to conduct educational and control programs. None of these agencies has sufficient resources at present for these tasks, but neither does NIH. Each of these agencies already has specific functions in the areas mentioned whereas for NIH a new function would have to be created, possibly at the expense of the existing programs and certainly with increasing fragmentation of Federal efforts. Only in the areas of the

development and application of low-profit technology[2] can an argument be made for greater involvement of NIH or other Federal agencies in transfer and application. In this case, NIH has a responsibility to identify such opportunities and to stimulate their development.

In assessing the activities associated with knowledge transfer we especially recognize that existing study methods for health care research are not very effective. Indeed, it is arguable whether targeted studies will ever be as effective as the carefully monitored medical marketplace for evaluation of health care strategies.

Recommendation 5 f) The support of targeted research through the use of selected clinical trials in appropriate areas and interdisciplinary centers is an appropriate mission of NIH.

g) NIH or other Federal agencies should be charged with the development of low-profit technology. NIH should participate in developing demonstration and education strategies and should also participate in supporting the training of the specialists needed for this mission.

h) The research mission of NIH should not be compromised by adding the requirement that it serves as the primary agency for technology transfer.

Strengthening the Institutions which Perform Research: The AAMC has emphasized repeatedly the strengths and the problems of the academic institutions which perform most of the biomedical and behavioral research in the United States. The reimbursement of the full costs of research to these academic medical

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[2] Low profit technology exists where the clinical application of a research finding is so limited as to discourage the investment of private development capital.

centers remains an important recommendation. Several studies have found no basis for allegations that indirect cost monies have been used inappropriately. In fact, studies conducted for the President's Biomedical Research Panel demonstrated that the financial stability of performer institutions has been impaired by their inability to receive full reimbursement for the research activities of their faculty. Because much of the nation's biomedical and behavioral research is carried out in academic medical centers, the need for strong and stable research and research training programs must be recognized and assured.

The AAMC has become increasingly concerned that the funding for another category of research award, the Biomedical Research Support Grant, has been the object of pressures for termination. Frequently used for start-up or transition support for imaginative and exploratory research projects, these flexible institutional funds are vitally important to furthering the missions of both the the NIH and the medical schools. Their purpose and importance, however, have been widely misunderstood and it is necessary to emphasize the role of these grants in providing stability and flexibility in research programs.

Another area of concern to academic medical centers is the age and condition of their research facilities and equipment. In many instances these facilities were constructed and equipment purchased many years ago. A number of Federal laws have required changes in facilities for which very limited funds have been available. The upgrading, renovation, and maintenance of deteriorating equipment and facilities as well as the need to purchase modern, more complex and expensive equipment has become increasingly

urgent if this country is to maintain its leadership in biomedical and behavioral research. Non-federal funds for these purposes are rarely available.

Recommendations 5 i) The AAMC urges increased Federal effort to stablize research opportunities through the full reimbursement of research costs (including indirect costs and depreciation expenses) and a renewed commitment to the Biomedical Research Support Grant.

j) The AAMC recommends funding for the construction and renovation of biomedical and behavioral research facilities, and for the purchase and maintenance of research equipment.

Relationship Between the Federal Government and Academic Institutions: The AAMC is concerned about both the propriety and cost of unchecked Federal intrusion into the academic research environment. Federal regulation may become "over-regulation," especially as compliance requirements are imposed by both the Federal legislative and executive branches and by state and local governments, often acting independently and without awareness of the cumulative cost such regulations have on multi-purpose academic institutions. Each agency may impose a few regulations which when aggregated become intolerable in terms of cost of compliance, administrative delays and paper work, and which may even conflict in purpose. For example, Occupational Safety and Health Administration regulations affect research laboratories in many ways mandating expensive and often ludicrous changes on those laboratories. The Departments of Transportation, Interior and HEW all have regulations relating to experimental animals. Even affirmative action has had an impact on research costs. Clearly, Federal oversight is needed, but better coordination is necessary.

The Government should also be aware of the unbalancing effect of certain Federal programs on the academic institutions which carry them out, since the performer institutions usually have a number of goals that are not all congruent with the Federal goals. For instance, Federal regulations may seriously distort the academic environment by making it necessary for the institution to alter some of its programs in order to comply with all the requirements of Federal sponsored programs.

Recommendation 5 k) The AAMC recommends that more careful attention be given to the costs and unintended effects that administrative requirements and regulations have on the ability of institutions to perform their research mission. The Federal government should strive toward a goal of minimizing the burdens imposed by regulations.

Health Planning Legislation: The health planning legislation poses similar regulatory hazards to biomedical and behavioral research. Although the language of the Senate Report on P.L. 93-641 specifically exempts "health education and research" from the purview of local Health Systems Agencies, it is not clear if this intent will be upheld in final planning regulations. Biomedical research is planned on a national basis to meet national needs. The AAMC recognizes that in some cases, particularly in clinical research, research grants may have an impact on local health care facilities. However, such impacts are small compared to the total health care delivery system. The imposition of local planning processes on biomedical and behavioral research makes possible unintentional disortion of national goals as, for example, in the approval of facilities for clinical research centers. The AAMC urges academic scientists to work with local HSA's to increase their understanding of the goals and programs of medical schools.

Recommendation 5 l) Medical research programs should not be subject to review or control by local HSA's.

GOAL 6: ASSURE ADEQUATE SUPPORT FOR ALL ASPECTS OF THE RESEARCH PROCESS.

In the past 10 years total national expenditures from all sources for biomedical research and development have increased two and one-half times. In 1975 the total amount invested in these activities was 4.6 billion dollars. However, during the same decade total national expenditures for health tripled. As a result biomedical research expenditures declined as a percentage of total health expenditures from a high of 5% in 1966 to 3.8% in 1975. This is a low rate of investment for a research dependent industry in which new knowledge must be viewed as the best long term strategy to understand, cure, ameliorate and prevent disease. While it is true that research has led to better understanding of the outcome of disease, this has often led to expensive "half-way technologies" which deal with the results of disease processes. Although only partially satisfactory, those technologies often represent the best or only treatment available to the practitioner. Far better for the control of cost of disease-- and far more difficult to achieve--is research which leads to the prevention of disease before it occurs.

It has been suggested that support for biomedical and behavioral research be fixed as a percentage of national health expenditures and a frequently cited figure has been five percent. However, the escalation of national health expenditures due to increases in health care services provided through third party payments, rising labor costs, and greater use of expensive diagnostic procedures and "half-way technologies" makes a fixed percentage rate hard to justify.

Therefore, it is more reasonable to relate future funding for biomedical research to current levels of support with annual adjustments for inflation, for the increased cost of sophisticated investigative tools and for investment in new and promising areas of research as they emerge.

The financing of biomedical and behavioral research should also be considered in terms of its sources. For many years the Federal government has funded about 60% of the investment in biomedical and behavioral research and development (primarily in the form of support for research), industry has funded 25 to 30% (primarily in support for development activities) and state and private sources account for the remaining 10% to 15%. Even though this arrangement is complex it has worked well and the public has benefited from the research and development process. The nation's biomedical research endeavor has been very productive in the last three decades but much better understanding of the fundamental nature of health and disease must still be achieved through research. Thus, it will be necessary for the foreseeable future to continue an emphasis on research and the Federal government, as in the past, is the logical sponsor for the primary research role.

The magnitude of the Federal involvement in biomedial and behavioral research is such that it is unlikely that any other organization, public, or private can provide the necessary impetus should Federal support falter. The record of NIH support to basic research in the past is unexcelled. However, in recent years short term goals have been increasingly emphasized and the impatience of the public, as perceived by their Congressioal representatives, for the transfer of knowledge to clinical applications has been translated into legislative

mandates for targeted programs. While impatience is understandable, it has been clearly pointed out that clinical advances depend on the often uneven but stepwise discovery of basic knowledge. These observations provide eloquent evidence for the value of vigorous programs of basic research of the highest quality and maximum breadth. Such programs should be maintained in each Institute of NIH and ADAMHA. The basic mechanism of support for this type of research should remain the traditional investigator-initiated grant and program project grants. Only rarely are other funding mechanisms appropriate for support of basic research.

Despite the importance of their role, the number of physician-scientists applying for and obtaining federal research project support in clinical areas has declined over the last ten years. The reasons for this decline are not apparent at this time but the participation of physician-scientists in applied research is essential for the vitality of the research process. The best method of support of applied research is through traditional individual and program project grants, whether from the Federal government, from private foundations or from industry.

Activities to test the safety and effectiveness of new biomedical knowledge, to demonstrate new technology to health care personnel and to educate the public about the significance of new research discoveries are very difficult to control or perform well. The need for determination of cost effectiveness, education and demonstration projects, and dissemination of new technology is unquestionable. The AAMC suggests that responsibility for these activities should be shared by public agencies, by private philanthropy and by industry. The public sector cost of these activities could be borne by a revolving fund

established in DHEW equal to a small percentage of the total Federal health care budget. This fund should be clearly separated from the budgets for biomedial and behavioral research. An agency responsible to the Assistant Secretary for Health, DHEW, and assisted by an advisory council which includes public members should make appropriate allocations of these funds to the proper agencies, to academic institutions or to industry.

The Federal involvement in training of researchers has, in recent years, reached levels of about 180 million dollars annually. These sums support the training of about 12,000 persons annually - clearly an effort beyond the capability of the private sector. Since 1973 programs for the training of new investigators have been marked by uncertainties of purpose and of funding, by impoundment and subsequent release of training funds, and by continued fluctuations in appropriated funds. These uncertainties have been noted by young people contemplating a research career and indications now exist that the pool of future researchers may be in jeopardy. Because research is primarily an activity of young inquiring minds, it is essential to take steps to make research careers more available and attractive to young persons with the talent, motivation and dedication upon whom the continuity and productivity of research depends.

The AAMC has repeatedly urged strong support for biomedical and behavioral research training through the institutional training grant, especially for pre-doctoral trainees in the basic sciences and post-doctoral trainees in the clinical sciences who are receiving their first exposure to research training.

The individual fellowships should continue for trainees of proven research capabilities who compete on a national level for funding. Efforts must be made to synchronize the application process to the training process. The NIH, working with the training institutions, should give high priority to a program of oversight of the training grants to assure a commitment to train only highly qualified trainees a large fraction of whom should go on to productive academic and research careers. Peer review of the training institutions should be utilized to assure this end.

Recommendation 6

a) To protect their health and improve management of their illnesses the American people should continue their commitment to biomedical and behavioral research supported from diverse sources. Stable funding should be assured and adjusted annually to reflect research needs and costs and to permit exploitation of new research and development opportunities. The Federal government's primary but not exclusive role in this area is affirmed.

b) AAMC strongly endorses the investigator-initiated project grant as the most appropriate mechanism of support of basic and applied research. Consequently, investigator-initiated projects should have priority over centrally directed funding mechanisms which are more appropriate for clinical trials, research/demonstration centers and other targeted activities. Any erosion of support for investigator-initiated activities, regardless of cause should be immediately remedied.

c) A vigorous program of high quality research applied to clinical problems should be supported by Federal grants, private philanthropy and by industry.

d) The transfer of research-proven technology to health care should be the mission of a number of Federal agencies, private organizations and industry. A fund for the support of technology transfer activities should be created and related to the health care budget. It should be administered by an agency responsible to the Assistant Secretary of Health assisted by an advisory council.

e) The institutional training grant should be the principal means of assuring an adequate supply of research manpower. Such training grants should receive external review of both the trainees and the training sites. Administrative oversight should be employed to insure continuity and quality of training.

f) A vigorous program of post-doctoral fellowships should be supported as a valuable adjunct to the institutional training grant.

g) The Federal government must make a concerted effort to eliminate instability of funding and poor timing in the training application process.

THE CONGRESS, FEDERAL REGULATIONS AND THE ACADEMIC COMMUNITY

Over the past five years, subtle but significant changes have occurred in the shape of the laws enacted by Congress and in the Federal regulations written by the Executive Branch to implement those laws. The tendency of the Congress, particularly during the Nixon years, was to enact increasingly specific laws which spelled out in a degree of detail formerly reserved for the regulatory process not only the intent of the law but the exact means by which the law was to be enforced. This tendency was in part an effort by Congress to ensure that the Executive Branch carried out the spirit and letter of its laws.

An example of this trend was the enactment in 1974 of the National Research Service Awards Act in which eight pages of legislation replaced a single phrase authorizing the Public Health Service to ... "conduct research training." The regulations and other issuances which implemented those eight pages of legislation run to dozens of pages of fine print in the Federal Register. The impact of the law and of these regulations on the academic community, notwithstanding the beneficial intent of the law as enacted, has been far-reaching, as is known by all members of the academic community.

As the length of legislative acts increases, the tendency has been for the agencies to increase their own output. For example, the Food and Drug Administration's Medical Device Amendments of 1976 were approximately twenty pages in length but have led to a proliferation of regulations which in 1977-78 amounted to more than 200 three-column pages of the Federal Register. Further, the regulations issued by FDA deal with a variety of subjects such as institutional review boards for human experimentation and regulations in these areas are in basic conflict with regulations on IRBs issued by other agencies, including agencies within the same department of the government (in this case, NIH--an agency of the DHEW).

The lack of coordination between agencies is increasing at an alarming rate, although some steps are being taken to decrease the inefficiency and waste. In HEW, for example, the Clinical Laboratory Improvement Act of 1967 has generated regulations which are being argued over by the Center for Disease Control (an arm of the Public Health Service) and by the Social Security Administration (an operating arm of the Health Care Financing Administration). If the Clinical Laboratory Improvement Act of 1978 with its broader scope of authority is enacted, the number of agencies within the Department of Health Education and Welfare who are affected by the new law will multiply. In addition to CDC and SSA, the NIH, the FDA (Bureau of Biologics), and other offices will become involved and may issue additional and possibly conflicting regulations.

AAMC and other organizations in the health field have hoped for some time that the tide will swing to deregulation rather than to increased regulations. The recent example of deregulation of the nation's airline industry is a hopeful sign. But there has appeared at the same time to be a tendency on the part of Congress to trust the health agencies even less. As a manifestation of this tendency, the Bureau of Health Manpower which generally has followed closely the letter of the authorizing health manpower legislation has recently

shown a tendency to write regulations which require changes in curriculum or which specify qualifications of faculty who will participate in programs funded by the Bureau.

Discussion of these points will be held during the CAS Business Meeting to plan ways in which the tide of intrusive legislation and excessive regulation can be stemmed or even turned.

GRADUATE MEDICAL EDUCATION

AAMC TASK FORCE ON GRADUATE MEDICAL EDUCATION:

The Task Force on Graduate Medical Education chaired by Jack Myers, M. D., received financial support in March 1978 from the Kaiser Family Foundation, the Kellogg Foundation, and the Education Foundation of America. The Task Force has moved ahead and established working groups on: The transition between undergraduate and graduate medical education, the quality of graduate medical education, the accreditation of graduate medical education, and specialty distribution in graduate medical education. A working group on the financing of graduate medical education will be appointed during the winter. Working groups are made up of individuals with significant involvement in graduate medical education both at their institutions and on the national level.

The Transition Working Group, chaired by D. K. Clawson, M. D., has completed its work. Its proposal to change the designation and accreditation of the types of graduate programs from the present Categorical, Categorical*, and Flexible to simply Categorical and Mixed has been widely circulated and formed the basis for a discussion of the issue of the broad clinical year at a September meeting of Residency Review Committee Chairman and LCGME representatives. The Transition Working Group has also recommended modifications in the application process and selection cycle. These recommendations, which include the development of a universal application form, will be presented to the Executive Council and be distributed early in 1979.

The Quality Working Group is directing its attention to the need for greater institutional responsibility for graduate medical education and the need of program directors and faculty for assistance in developing programs and evaluating residents' performance.

The Accreditation and Specialty Distribution Working Groups will first meet in November 1978.

THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION:

The Liaison Committee on Graduate Medical Education has continued its effort to improve the quality and effectiveness of the review and accreditation process. While AMA staff changes have provided a modicum of improvement in the implementation of LCGME policies and procedures, the AAMC, the American Board of American Specialties, and the Council of Medical Specialty Societies are persisting in their request that the LCGME and Residency Review Committees be staffed independently of the AMA and other sponsoring organizations. The Coordinating Council on Medical Education has appointed a Commission consisting of two representatives from each of the five sponsoring organizations which is chaired by Janet Skadan, the CCME's public member, to study the problem of LCGME staffing and relationships with RRC's. The Commission has held its first meeting and is expected to report this year.

GENERAL REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION:

After allowing ten months for comment on a draft released in August 1977, the LCGME's Subcommittee on Essentials has finalized a new set of General Requirements and forwarded them to the LCGME. After LCGME action, they will be forwarded to the Coordinating Council on Medical Education for approval by the five sponsoring organizations.

ACCREDITATION OF SUBSPECIALTY TRAINING PROGRAMS:

The LCGME has reopened the issue of how to accredit subspecialty training programs effectively. A subcommittee charged to review the entire accreditation process for graduate medical education has been appointed. This subcommittee and the Subcommittee on Essentials will be working together to develop a plan to encompass subspecialty training programs into the accreditation system.

FOREIGN MEDICAL GRADUATES:

Implementation of the amendments to the Immigration Act embodied in Public Law 94-484 has been accomplished with little apparent disruption. Twelve institutions have been granted waivers which permit them to enroll ECFMG certified FMGs who have not passed the Visa Qualifying Exam. The ECFMG anticipates that another 18 to 20 waivers may be granted.

HOUSE STAFF UNIONIZATION:

H. R. 2222, a bill which would provide for recognition of house staff unions in private hospitals by the National Labor Relations Board, was reported out of Committee and was granted a rule by the House Rules Committee but has not been acted upon at this writing.

GRADUATION QUESTIONNAIRE:

The AAMC prepared and distributed through the Deans' offices of the medical schools a questionnaire to be completed by all graduating seniors. 7,849 usable forms were returned representing a response rate of 54%. This first effort to survey graduating seniors will be repeated in subsequent years. The questionnaire is particularly directed toward determining the effect of the undergraduate medical education experience on specialty choice and career plans. Reports on each school's graduates combined with national data have been sent to the Deans' offices.

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CAS Services Program

In August of 1977, AAMC initiated a two-year experimental program of increased services to member CAS societies which desired support and services over and beyond the level routinely provided to all CAS societies. The purpose of the CAS Services Program is to provide subscribing societies the services they need to accomplish their goals and to develop a closer relationship between the societies and AAMC.

The Services Program is administered through the Division of Biomedical Research of the Department of Academic Affairs. It was prompted by the AAMC's desire to initiate more effective communications with CAS societies and their members. The range of policy interests of the sixty CAS societies is extensive, and AAMC wishes to be more aware of the particular concerns of individual organizations. Hopefully, better two-way communication will result which will strengthen AAMC's representation of CAS societies as well as improve individual societies' policymaking functions on behalf of their own members' interests.

Staffing costs to individual societies depends upon the amount of services required, but by sharing staff two or three societies can achieve their needs efficiently. During the experimental two years, the AAMC is not charging overhead costs (e.g. rent, heat, contributions to the effort by other AAMC staff) and is providing the funds needed to support the direct staff efforts which are not covered by participating societies. Whether the program will extend beyond the two year experimental period will be based upon judgment of the satisfaction of the societies with the services provided and of the program's effectiveness in strengthening the accomplishments of the Association's responsibility to all its constituents. After June 1979, participant societies will be expected to meet overhead costs as well as staff and other direct costs.

Subscribers to the CAS Services Program at this time are the Association of Professors of Medicine and three neurological societies--the Association of University Professors of Neurology, the American Academy of Neurology, and the American Neurological Association. The Association of Professors of Medicine has contracted with AAMC to receive a broad level of support services including meeting arrangements, maintenance of membership rosters and financial records, preparation of newsletters, and keeping the officers and membership abreast of issues related to their specific interest. The neurological societies have subscribed to the CAS Services Program to receive continual information about legislation and national activities pertinent to neurology. The AAMC has received formal inquiries from twelve other societies and may extend the program to one or more organizations in the near future.

HANDICAPPED REGULATIONS AND THE AAMC SPECIAL ADVISORY PANEL ON TECHNICAL STANDARDS FOR MEDICAL SCHOOL ADMISSION

Although regulations implementing Section 504 of the Vocational Rehabilitation Act of 1973 were published by the Department of Health, Education and Welfare more than a year ago, the impact of these regulations on the medical school admissions process remains unclear. The regulations specify that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal assistance." The regulations further define a qualified handicapped person as one who meets the academic and technical standards requisite to admission or participation in an education program. A survey of medical schools revealed that although academic standards for admission are generally clearly defined, few schools had developed technical standards. To assist schools in this process, the AAMC Executive Council established a Special Advisory Panel on Technical Standards for Medical School Admission under the chairmanship of Dr. M. Roy Schwarz, Associate Dean for Academic Affairs, University of Washington, and charged the Panel with assessing how schools might best meet this challenge.

The Panel has met with a representative of HEW's Office of Civil Rights, the enforcing authority for the law and regulations. The Panel has become concerned about the apparent lack of understanding of the medical education process in that office and fears incursion by HEW into both the admissions process and curricular determinations.

The several court cases that have arisen concerning the admission of handicapped individuals to education programs do not provide clear-cut guidelines to schools. A Fourth Circuit Court of Appeals decision frequently cited by HEW stated that an individual applicant need not be required to perform in all areas of competence associated with the particular professional career in order to be considered a qualified applicant for admission to a program. The impact of such a decision on the traditionally broad-based and undifferentiated M.D. degree may be significant. The final report of the Special Advisory Panel is expected by the end of this year. In the meantime, the AAMC has encouraged its constituent institutions to develop guidelines that prevent overt and unjustified discrimination against the handicapped while maintaining the integrity of the medical curriculum.

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OPHTHALMOLOGY AND OTOLARYNGOLOGY
Amer. Academy of Ophthalmology and Otolaryngology
Charles Krause
Joel G. Sacks, M. D.
David J. Noonan (PAR)
Assoc. of University Professors of Ophthalmology
Dr. David Paton
Henry J. L. Van Dyk, M. D.
Herbert E. Kaufman, M. D. (PAR)
Soc. of University Otolaryngologists
George A. Gates
M. Stuart Strong, M. D.
Willard B. Moran, Jr., M. D. (PAR)

ORTHOPAEDICS
Amer. Academy of Orthopaedic Surgeons
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Charles V. Heck, M.D.
Assoc. of Orthopaedic Chairmen
Donald A. Nagel, M. D.
Donald B. Kettelkamp, M. D.
Warren Stamp, M. D. (PAR)

PATHOLOGY
Amer. Society of Clinical Pathologists
John Bernard Henry, M. D.
Joseph H. Keffer, M. D.
Rex B. Conn, M. D. (PAR)
Assoc. of Pathology Chairmen, Inc.
Dr. Ellis Benson
Dr. William H. Hartman
Rolla B. Hill, Jr. M. D. (PAR)

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Amer. Pediatric Society
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Floyd W. Denny, M. D.
Assoc. of Medical School Pediatric Dept. Chairmen, Inc.
Dr. T. K. Oliver, Jr.
Leo Stern, M. D. (PAR)
Society for Pediatric Research
Virginia V. Weldon, M. D.
Anne A. Gershon, M. D. (PAR)

PHARMACOLOGY
Amer. Society for Clinical Pharmacology and Therapeutics
F. Gilbert McMahon, M. D. (PAR)
George N. Aagard, M. D.
Assoc. for Medical School Pharmacology
Dr. Frank Standaert
Dr. H. G. Mandel
Joseph K. Bianchine (PAR)

PHYSIATRY
Assoc. of Academic Physiatrists
Alicia Hastings, M. D.
Ian MacLean, M. D.

PHYSIOLOGY
Amer. Physiological Society
Robert M. Berne, M. D.
Franklyn G. Knox, M. D.
Dr. Brian A. Curtis, Asst. Dean (PAR)
Assoc. of Chairmen of Departments of Physiology
Dr. James B. Preston
Dr. William F. Ganong
Dr. Donald Rennie (PAR)

PLASTIC SURGERY
Amer. Association of Plastic Surgeons
Dr. Robert L. Harding
Milton T. Edgerton, M. D. (PAR)
Educational Foundation of the Amer. Soc. of Plastic and Reconstructive Surgeons
John B. Lynch, M. D. (PAR)
Norman E. Hugo, M. D.
Plastic Surgery Research Council
John E. Hoopes, M. D. (PAR)
Thomas J. Krizek, M. D.

PREVENTIVE MEDICINE
Assoc. of Teachers of Preventive Medicine
Robert Berg, M. D.
Dr. Steven Jonas
David Rabin, M. D. (PAR)

PSYCHIATRY
Amer. Assoc. of Chairmen of Departments of Psychiatry
David R. Hawkins, M. D.
Daniel Freedman, M. D.
Paul Jay Fink, M. D. (PAR)
Assoc. for Academic Psychiatry
Dr. Layton McCurdy
Paul J. Fink, M.D.
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Assoc. of University Radiologists
Lee F. Rogers, M. D.
Henry Goldberg, M. D.
Mark Mishkin, M. D. (PAR)
Soc. of Chairmen of Academic Radiology Departments
Harold G. Jacobson
James Youker, M. D.

SURGERY
Amer. Association for Thoracic Surgery
Clarence Schock Weldon, M. D.
Judson G. Randolph, M. D.
Amer. Surgical Association
Dr. J. W. Cole
Assoc. for Academic Surgery
P. William Curreri, M. D.
Patricia Numann, M. D.
Everett V. Sugarbaker, M. D. (PAR)
Soc. for Surgery of the Alimentary Tract, Inc.
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Keith A. Kelly, M. D.
Paul H. Jordan, Jr., M. D. (PAR)
Soc. of Surgical Chairmen
James Hardy, M. D.
Dr. W. Dean Warren

SURGERY (Cont.)
Soc. of University Surgeons
Olga Jonasson, M. D.
Richard L. Simmons, M. D.

UROLOGY
American Urological Association
Dr. Harry C. Miller (PAR)
Soc. of University Urologists
William L. Parry, M. D.
James F. Glenn, M. D.
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