



association of american  
medical colleges

# COUNCIL OF ACADEMIC SOCIETIES

## 1982 ANNUAL MEETING

### Washington Hilton Hotel

### Washington, D.C.

#### THE AAMC GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN PROJECT: A STUDENT/FACULTY COLLOQUY

The shift toward specialized medical practice has modified the major obligation of an educational program leading to the M.D. degree from that of educating students who will become practitioners after one year of internship to educating students who will continue into a specialized graduate phase. Its goal, in other words, has changed from one of educating general practitioners to one of providing the general professional education of future specialized practitioners. For this reason, the AAMC has undertaken a three-year project, supported by a grant from the Henry J. Kaiser Family Foundation, to review and appraise the *general professional education* of the physician and college preparation for medicine. The purposes of the project are: (1) to assess the present approaches to the general professional education of the physician and college preparation for medicine and to develop recommendations and strategies for improvement and (2) to stimulate broad discussions among medical school and college faculties and their disciplinary societies about their philosophies and approaches to medical education and college preparation for medicine.

Working groups have been appointed to consider three facets across the premedical, preclinical, and clinical phases of medical education:

**Essential Knowledge:** The knowledge that all students must acquire to provide the foundation for later specialized education and for continued learning throughout their professional careers.

**Fundamental Skills:** Those skills that all students should attain during college and medical school as the basis to continue their learning beyond medical school, to apply scientific principles to the solution of clinical problems, and to carry out those tasks that are unique to a physician's role.

**Personal Qualities, Values, and Attitudes:** Those traits that all physicians should possess including curiosity, intellectual drive, imagination, emotional stability, ethical integrity, and humaneness.

On November 7, the Council of Academic Societies and the AAMC Organization of Student Representatives will hold a joint session to consider the General Professional Education of the Physician Project as a whole and to discuss the topics of the three working groups. Registration information and the schedule for the November 7 and 8 CAS Meetings appear on the following pages.

## HOTEL RESERVATIONS

The 1982 AAMC Annual Meeting preliminary program was mailed to all CAS officers and representatives in August. Those who wish to attend the November 7-8 CAS meetings should register for the AAMC meeting and make hotel reservations using the forms included in the preliminary program. Please keep in mind that accommodations at the headquarters hotel (the Washington Hilton) are limited and assigned on a first-come, first-served basis. If you wish to stay at the Hilton, you should return the registration and reservation forms immediately. Additional preliminary programs may be obtained by calling 202-828-0480.

## REGISTRATION INFORMATION

If you will only be attending the November 8 CAS Business Meeting, it is not necessary for you to return the registration form below. However, if you wish to attend the November 7 CAS/OSR sessions, you must register in advance.

To cover the cost of the reception, a registration fee of \$20.00 will be charged. Please complete the form below and enclose it with your check made payable to AAMC. Return to:

Lynn Morrison  
Staff Associate  
Department of Academic Affairs  
AAMC  
One Dupont Circle, N.W. #200  
Washington, D.C. 20036

Be sure to indicate your first and second choice discussion groups by placing a "1" and a "2" in the appropriate boxes. If you have questions, call 202-828-0480.

THIS REGISTRATION FORM MUST BE RETURNED NO LATER THAN OCTOBER 8

*cut along this line*

CAS REGISTRATION FORM

PLEASE PRINT!

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

SOCIETY: \_\_\_\_\_

Place a "1" in the box next to the discussion group you would prefer and a "2" in your second choice discussion group.

☐

Essential Knowledge

☐

Fundamental Skills

☐

Personal Qualities, Values and Attitudes

I will \_\_\_\_\_ attend the reception on Sunday, November 7 and have enclosed a check for \$20.00

I will not \_\_\_\_\_ attend the reception.

SUNDAY, NOVEMBER 7

1:30 P.M.

CAS PLENARY SESSION

CONSERVATORY ROOM

*The Enigmatic Future and Tumultuous  
Past of Medical Education*

Stanley J. Reiser, M.D.  
Professor of Humanities and Technology  
in Medicine  
University of Texas Health Science  
Center at Houston

2:30 P.M.

CAS/OSR PLENARY SESSION

CONSERVATORY ROOM

Presentations by the Chairmen of the  
Three Working Groups:

John A. Gronvall, M.D.  
Professor of Pathology  
University of Michigan Medical School  
Chairman, Working Group on Essential Knowledge

Victor R. Neufeld, M.D.  
Professor of Medicine  
Director, M.D. Programme  
McMaster University  
Chairman, Working Group on Fundamental Skills

Robert L. Kellogg, Ph.D.  
Dean, College of Arts and Sciences  
University of Virginia  
Chairman, Working Group on Personal  
Qualities, Values and Attitudes

3:30 - 5:30 P.M.

CAS/OSR DISCUSSION SESSIONS

(ROOMS TO BE ASSIGNED)

Students and Faculty will meet in small  
groups to discuss the working group  
topics.

6:00 - 8:00 P.M.

CAS/OSR COCKTAIL RECEPTION

LINCOLN EAST ROOM

MONDAY, NOVEMBER 8

1:30 - 5:30 P.M.

CAS BUSINESS MEETING

BALLROOM EAST

Update on Legislative and Other Issues  
Election of Administrative Board and New Members

Background materials for the CAS/OSR sessions and the agenda for the November 8 business meeting will be mailed to all CAS officers and representatives in mid-October.

Information regarding other AAMC sessions of particular interest to faculty is attached.

## OTHER AAMC SESSIONS

This supplement to the CAS meeting announcement has been prepared to provide information about other annual meeting activities of particular interest to faculty. Please note that it does not list all sessions; a more complete listing of activities including individual society meetings may be found in the AAMC preliminary program.

### MONDAY, NOVEMBER 8

9:00 A.M. - NOON

#### AAMC PLENARY SESSION

BALLROOM

##### "ACADEMIC VALUES IN A CHANGING ENVIRONMENT"

*Social Climate of the 1980s and Implications  
for Medical Delivery Systems*

Florence Skelly  
Yankelovich, Skelly and White

*Changing Economic Environment*

Honorable Donald Regan  
Secretary of the Treasury

*Social Determinants of Political Change*

Alan Pifer  
President, Carnegie Corporation of New York

*Numbers Versus Values or Who's on First?*

Elliot Richardson  
Milbank, Tweed, Hadley and McCloy

### TUESDAY, NOVEMBER 9

8:15 A.M. - 9:00 A.M.

#### AAMC ASSEMBLY

BALLROOM WEST

9:00 A.M. - 11:00 A.M.

#### AAMC PLENARY SESSION

BALLROOM

Presentation of AAMC Award for  
Distinguished Research

Presentation of Flexner Award

*Preservation and Discovery: The Research  
University*

Hanna H. Gray  
President, University of Chicago

*Can An Invisible Hand Feel the Difference  
Between a Strong and a Weak Carotid Pulse?*

Sherman M. Mellinkoff, M.D.  
Dean, UCLA School of Medicine

*Chairman's Address*

Thomas K. Oliver, Jr., M.D.  
AAMC Chairman

2:00 P.M. - 4:00 P.M.

AAMC SPECIAL GENERAL SESSION

BALLROOM EAST

"GERIATRICS AND MEDICAL EDUCATION"

Moderator: Richard Janeway, M.D.  
Dean, Bowman Gray School of  
Medicine

Robert N. Butler, M.D.  
Chairman, Department of Geriatrics and  
Adult Development  
Mt. Sinai School of Medicine

Joseph E. Johnson, III, M.D.  
Chairman, Department of Medicine  
Bowman Gray School of Medicine

William H. Gurtner  
Executive Vice President  
Mt. Zion Hospital and Medical Center  
San Francisco

John Rowe, M.D.  
Director, Division on Aging  
Harvard Medical School  
Director, GRECC, VA in Boston

WEDNESDAY, NOVEMBER 10

1:30 P.M. - 5:45 P.M.

RESEARCH IN MEDICAL EDUCATION CONFERENCE

At each AAMC Annual Meeting, the Group on Medical Education sponsors a Conference on Research in Medical Education (RIME). The purpose of the conference is to provide a forum for the presentation and discussion of studies concerning the process of medical education. The conference has two types of sessions: paper presentations for discussion of current research, and symposia to explore issues of pending interest. More detailed information regarding the topics for the papers which will be presented and the panelists for the symposia may be obtained by calling Karen Fritz at 202-828-0560. Copies of the RIME conference proceedings, including the research papers to be presented and the panelists for the symposia may also be obtained at a cost of \$15.00 by contacting Ms. Fritz and will be available during the meeting at the RIME information booth on the Concourse level of the Washington Hilton.



**AGENDA**  
**FOR THE**  
**COUNCIL OF ACADEMIC**  
**SOCIETIES**

NOVEMBER 7-8, 1982

Washington Hilton Hotel  
Washington, D.C.

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**  
*One Dupont Circle*  
*Washington, D.C. 20036*

AGENDA  
COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING

November 7-8, 1982  
Washington Hilton Hotel  
Washington, D.C.

I. MEETING SCHEDULE . . . . . i

II. DISCUSSION GROUP MATERIALS

Background materials for the November 7 discussion groups appear in the enclosed "Charges to Working Groups" for the General Professional Education of the Physician Project.

Essential Knowledge . . . . .	7
Fundamental Skills . . . . .	21
Personal Qualities, Values, and Attitudes . . . . .	33

III. CAS BUSINESS MEETING (November 8)

A. Consideration of Minutes of CAS Business Meeting, November 2, 1981 . . . . .	1
--	---

B. Action Items

1. Election of Academic Society Members . . . . .	9
2. Election of Members to the 1982-83 Administrative Board . . . . .	12

C. Discussion Items

1. Follow-up on November 7 CAS/OSR GPEP Discussion Sessions	
2. Legislative Update . . . . .	18
● FY 1983 Appropriations . . . . .	19
● Animal Research Legislation . . . . .	23
● NIH Renewal Legislation . . . . .	26
● Establishment of Separate Institutes at NIH . . . . .	30
3. Changes in Medicare Reimbursement Policies . . . . .	31
4. AAMC Response to Enactment of the Small Business Innovation Development Act . . . . .	33
5. Evaluation of the Performance of Clinical Clerks . . . . .	42

6. Declining Applicant Pool . . . . .	54
7. Declining Numbers of GME Positions . . . . .	58
8. Interim Meeting Plans . . . . .	64
C. <u>Information Items</u>	
1. General Professional Education of the Physician Project Hearings . . . . .	65
2. Financial Assistance for Medical Students . . . . .	67
3. Regional Institutes on Geriatrics and Medical Education Project . . . . .	68
4. Future Meeting Dates . . . . .	69
D. Chairman's Report	
E. Adjournment	



MEETING SCHEDULE  
COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING  
November 7-8, 1982

SUNDAY, NOVEMBER 7

1:30 p.m. CAS PLENARY SESSION CONSERVATORY ROOM

The Enigmatic Future and Tumultuous  
Past of Medical Education

*Stanley J. Reiser, M.D.*  
*Professor of Humanities and Technology*  
*in Medicine*  
*University of Texas Health Science*  
*Center at Houston*

2:30 p.m. CAS/OSR\*PLENARY SESSION CONSERVATORY ROOM

The AAMC General Professional Education  
of the Physician Project: A Student/Faculty  
Colloquy

Presentations by the Chairmen of the Three  
GPEP Working Groups:

*John A. Gronvall, M.D.*  
*Professor of Pathology*  
*University of Michigan Medical School*  
*Chairman, Working Group on Essential Knowledge*

*Victor R. Neufeld, M.D.*  
*Professor of Medicine*  
*Director, M.D. Programme*  
*McMaster University*  
*Chairman, Working Group on Fundamental Skills*

*Robert L. Kellogg, Ph.D.*  
*Dean, College of Arts and Sciences*  
*University of Virginia*  
*Chairman, Working Group on Personal*  
*Qualities, Values and Attitudes*

3:30 - 5:30 p.m. CAS/OSR DISCUSSION SESSIONS (Rooms to be Assigned)

CAS and OSR Representatives will meet in  
small groups to discuss the working group  
topics.

6:00 - 8:00 p.m. CAS/OSR COCKTAIL RECEPTION Lincoln East Room

MONDAY, NOVEMBER 8

1:30 - 5:30 p.m. CAS Business Meeting Ballroom East

\*AAMC Organization of Student Representatives



# association of american medical colleges

## MINUTES COUNCIL OF ACADEMIC SOCIETIES FALL MEETINGS

NOVEMBER 1-2, 1981

Washington Hilton Hotel  
Washington, D.C.

### BASIC SCIENCE EDUCATION AS THE FOUNDATION FOR ADVANCED MEDICAL PRACTICE

#### Plenary Session

A plenary session focused on the theme, "Basic Science Education as the Foundation for Advanced Medical Practice." Dr. Frederick E. Shideman, chairman of the department of pharmacology at the University of Minnesota, contrasted the content and scope of instruction in pharmacology in the past and the present and speculated briefly regarding the future. Dr. Rubin Bressler, chairman of the department of medicine at the University of Arizona, discussed the challenge for basic and clinical scientists to identify the essential bioscience concepts to be learned by students. Following these presentations, the Council adjourned for small group discussion sessions on related topics.

#### Discussion Group Reports

##### 1. The Appropriate College Preparation for Medical School

Dr. Virginia Weldon reported that this group had agreed that it would be very difficult to more specifically define or to redefine the appropriate college preparation for medical school. A complicating factor in the consideration of this issue was the variability of individual students, their educational backgrounds, and their future career goals. The group also felt that the educational prerequisites for medical school are less easily determined now than in the past because of the rapid pace at which new discoveries are altering the scientific foundation of medicine.

The group was able to identify several possible methods to strengthen the college preparation of medical students. It was suggested that colleges continue to maintain or aspire to high standards for promotion. It was pointed out that the overall trend in U.S. secondary and college education has been a drop in faculty expectations for student performance, and, consequently, a decline in student abilities as measured on standard achievement tests. It was also suggested that premedical advisors attempt to alleviate, rather than aggravate, college students' fears regarding the level of pressure in medical school. Closer interaction between premedical advisors and medical school admissions and promotion committees was also advocated.

##### 2. The Role of the Basic Scientists in Clinical Departments

Dr. William F. Ganong stated that data contained in a paper by Alfred P. Fishman and Paul Jolly entitled, "Ph.D.'s in Clinical Departments" had stimulated this group's lively discussion. The data showed that in 1978-79 there were a total of 4,604 full-time Ph.Ds in clinical departments compared with 6,456 in basic

science departments (excluding pathology). However, comparative data for 1970-71 through 1978-79 indicate that more Ph.Ds are opting to work in clinical departments than in basic science departments. (Between 1970-71 and 1978-79, 1,844 additional basic scientists became clinical department faculty, compared with 1,766 additional basic scientists in basic science departments.) The role of Ph.Ds in clinical departments for the most part is basic science instruction for residents and research. However, in some departments (particularly psychiatry, radiology, and rehabilitative medicine) basic scientists are actively involved in patient care.

The group identified higher salary levels as a major incentive for basic scientists to work in clinical departments. The average salary of basic scientists in clinical departments is \$3,000 per year higher than their colleagues in basic science departments. However, a number of disincentives were also identified:

1. Uneasiness Regarding Research Grant Support: Regulations in some states in fact prohibit funding support for basic scientists to participate in clinically-oriented projects.
2. Difficulty Obtaining Tenure: Only 28% of the basic scientists in clinical departments are tenured compared with 53% in basic science departments.
3. Personal Sense of Isolationism: Basic scientists in clinical departments often feel isolated from their colleagues and sense a lack of recognition for their work on the part of clinicians.

The group agreed that these issues merit further consideration by the CAS--in terms of their effect on basic science department manpower as well as on the training of clinicians.

### 3. Reinforcement of the Basic Sciences During Clinical Education

Dr. Brian Curtis reported on the deliberations of this group. Much of the discussion had focussed on the importance of providing students with a complete foundation of basic scientific knowledge during the pre-clinical years (an obvious prerequisite if the basic sciences are to be reinforced during clinical education). The group discussed ways to strengthen this foundation and agreed that basic science faculty should attempt to place greater emphasis on problem solving and the practical applications of bioscience knowledge and less on the instant recall of isolated facts. Essay rather than multiple-choice examination questions were advocated. The group also agreed that it may be appropriate to devote more of the medical school curriculum to basic science courses. It was agreed that part of the relatively unstructured fourth year of electives might be more appropriately invested in additional basic science instruction.

Regarding the reinforcement of the basic sciences during undergraduate and graduate clinical education, it was suggested that clinical faculty might foster the process by: 1) inviting basic scientists to participate in ward rounds to assist in illustrating the clinical applications of the basic sciences, and 2) devoting more of the clinical curriculum to conceptual teaching and less to procedurally-oriented education.

### 4. Identification of the Essential Scientific Concepts to be Learned by Students

Dr. David Brown reported on this group's discussion. Surprisingly, the group was composed solely of clinical scientists. More surprisingly, the clinicians agreed on the desirability of expanding the pre-clinical phase. They acknowledged that basic

science faculty require more time and less structure in which to present material-- particularly in view of the major basic scientific discoveries of recent years. The group also agreed that the content of clinical science courses should not be the overriding influence on the basic science curriculum. Basic scientists should be allowed to identify what they consider to be essential concepts and present them in a manner which demonstrates their applicability to the clinical concepts that will be taught subsequently.

In terms of promoting student understanding of the scientific foundation of medicine, it was agreed that both basic and clinical science faculty should: 1) expose students to research laboratory experience, and 2) attempt to present information in a conceptual framework rather than in a purely factual manner. It was suggested that clinical faculty should be less procedurally oriented in their teaching and instead strive to emphasize the pathophysiology of illness. The group agreed that these issues can be most appropriately addressed by the teaching faculty rather than the administration officials of each institution.

#### Guest Speaker

Dr. Robert W. Berliner, Dean of the Yale University School of Medicine, discussed the application of scientific knowledge to the future practice of medicine. Dr. Berliner expressed the opinion that the major basic science discoveries of recent years have been effectively incorporated into the medical education curriculum such that the practice habits of recently graduated physicians in the year 1990 will probably be up-to-date. However, he was somewhat less optimistic regarding the practice habits of this same group of physicians in the year 2000 and beyond when research advances will almost certainly have continued to alter the scientific foundation of the practice of medicine.

Dr. Berliner stated that it is very difficult (if not futile) to attempt to predict the future relevance of current scientific theories and thereby determine their importance as concepts which should be taught to students. However, he pointed out a number of ways (other than formal continuing medical education programs) that faculty can contribute to the development of the future physician's ability to assimilate and utilize new scientific developments:

1. assure that graduates have a foundation of general basic science knowledge on which to build by requiring a broad understanding of basic scientific principles rather than the memorization of the overwhelming intricacies of each discipline
2. test students in the practical applications of these basic principles rather than their ability to recall specific facts
3. teach students to examine new information critically so that in the future they can easily prioritize and determine the relevance of new developments
4. provide the opportunity for independent study, a habit upon which physicians must rely throughout their professional lives
5. provide students with a greater opportunity to participate in biomedical research

In addition to these suggestions, Dr. Berliner advocated a re-examination of the medical school curriculum to assess: 1) the advisability of devoting more time to basic science education; 2) whether the clinical phase is inordinately focused on teaching procedures which students will have the opportunity to learn later as residents; or 3) whether clerkship periods of equal duration in the standardly required clinical disciplines are the most appropriate division of the student's time. Dr. Berliner expressed the opinion that some disciplines, such as internal medicine, have comparatively broader applications and are, therefore, of more value in the development of a knowledge base for the future continuing education of the physician.

## BUSINESS MEETING

### I. CALL TO ORDER

The meeting was called to order at 3:00 p.m. Dr. Daniel X. Freedman, Chairman, presided. Sixty-seven individuals, representing 55 of the 71 member societies were present.

### II. APPROVAL OF MINUTES

The minutes of the October 27, 1980 CAS Business Meeting were approved as submitted.

### III. PRESIDENT'S REPORT

AAMC President, John A. D. Cooper provided an overview of the current political climate in Washington. Regarding the Reagan economic recovery plan, Dr. Cooper reported that the Administration was projecting an FY82 budget deficit of \$80-100 billion--at least twice the \$40 billion deficit which the President had initially anticipated. As might be expected, this disappointing outcome has only served to increase the President's determination to further reduce federal spending. Dr. Cooper predicted that the Administration's proposed budgets for the next several years will be increasingly austere and that the programmatic implications of funding reductions may be ignored in the interest of strengthening the economy. He expressed particular concern about expected cutbacks for the National Institutes of Health and the Guaranteed Student Loan Program.

Regarding the legislative branch, Dr. Cooper expressed concern regarding the growth of a number of congressional coalitions, such as the "boll weevils" (southern Democrats) and "gypsy moths" (midwestern and northeastern Republicans). He expressed the opinion that this fragmentation of Congress has the potential to weaken the federal legislative process and further tip the balance of power in favor of the immensely popular Reagan Administration.

In view of the current political and economic climate, Dr. Cooper emphasized the importance of unity among the faculty and administrators of the nation's academic medical institutions. He expressed appreciation for the active participation of the CAS in past AAMC legislative activities and encouraged the representatives present to be prepared to be optimally involved in the future.

### IV. ACTION ITEMS

#### A. New Members

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 applications of the following organizations for membership be approved by the full Council:

American Academy of Physical Medicine and Rehabilitation

American Society of Human Genetics

Child Neurology Society

Association of Directors of Medical Student Education in Psychiatry, Inc.

ACTION: The above applications for membership were unanimously approved.

NOTE: On November 3, 1981 by action of the AAMC Assembly, these societies were elected to AAMC membership, increasing to 75 the number of societies in the CAS.

B. Election of Members to the 1981-82 Administrative Board

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

Chairman-Elect

Frank C. Wilson, M.D., Representative, American Academy of Orthopaedic Surgeons;  
Chairman, Division of Orthopaedic Surgery, University of North Carolina

Administrative Board Members from the Basic Sciences

David H. Cohen, Ph.D., Representative, Society for Neuroscience;  
Chairman, Department of Neurobiology and Behavior, SUNY-Stony Brook

Douglas Kelly, Ph.D., Representative, Association of Anatomy Chairmen;  
Chairman, Department of Anatomy, University of Southern California

Administrative Board Members from the Clinical Sciences

Bernadine Healy Bulkley, M.D., Representative, American Federation for Clinical Research; Professor, Department of Medicine, Johns Hopkins University

T. R. Johns, M.D., Representative, American Academy of Neurology;  
Chairman, Department of Neurology, University of Virginia (to serve for one year, completing the current term of Dr. Frank Wilson)

V. DISCUSSIONS ITEMS

A. Legislative Update

Ms. Diane Plumb of the AAMC staff focused her remarks on three issues: the FY1982 NIH budget, small business set-aside legislation, and animal research legislation.

NIH Budget - Ms. Plumb reported that the Congress had not yet approved an FY1982 appropriations bill for health programs, and, therefore, the status of funding for NIH was still unclear. To further complicate the issue, in September President Reagan had requested an additional 12% across-the-board cut in all domestic spending. The President stated that he would veto any bill authorizing funding levels in excess of those called for in his economic recovery plan.

Small Business Set-Aside Legislation - Ms. Plumb explained that this legislation would require federal agencies with research and development budgets of over \$100 million to earmark a certain percentage of their budgets for allocation to small businesses. She reported that House Commerce Committee Chairman, John Dingell, had requested that the bill be referred to his committee for consideration. If hearings are held, the AAMC will seek to testify regarding the potential threat of this legislation to the viability as well as the integrity of agencies such as the NIH.

Animal Research Legislation - H.R. 556, the "Research Modernization Act of 1981," seeks to mandate the development of alternatives to in vivo methods and includes a proposal to require that Federal agencies expend at least 30% of their budgets in the development of in vitro testing methods. Ms. Plumb stated that because the Congress is currently pre-occupied with budgetary and defense matters, it is unlikely that this legislation will be acted upon in the immediate future. However, there is strong public pressure to impose limitations on animal research.

On a more positive note, Ms. Plumb reported on H.R. 4593 which proposes to permanently exempt National Research Service Awards under the IRS code. A comparable bill has not yet been introduced in the Senate but is expected soon.

Ms. Plumb and CAS Chairman Freedman reiterated Dr. Cooper's request for optimum involvement of CAS Representatives in these issues. Both emphasized the importance of faculty involvement in public affairs at a time when a number of legislative proposals threaten the foundation of the nation's biomedical research enterprise. Ms. Plumb stressed the importance of communication with members of Congress and their health aides by phone, by mail, or in person. Regarding personal visits, she stated that AAMC staff would welcome the opportunity to assist CAS Representatives in scheduling appointments or by providing appropriate background materials.

#### B. CAS Interim Meeting Plans

In view of the political developments which had been discussed, the Representatives present agreed that it would be timely to organize the 1982 Interim Meeting of the CAS as a public affairs symposium. It was agreed that key Congressional staff and Executive Branch agency officials should be invited for a plenary session and informal small group discussions. Ms. Plumb stated that to assure the optimum level of attendance by the invited guests, it would be necessary to schedule such a meeting in mid-January (prior to the release of the President's proposed FY1983 budget). The question was raised as to whether CAS Representatives

would be enthusiastic about returning to Washington that soon for another meeting of the Council. However, a show-of-hands indicated that the meeting would be well attended regardless of the timing.

C. Competition in Medical Care and Its Effects on Medical Education

Myles P. Lash, Executive Director of the Medical College of Virginia Hospitals, discussed the competitive marketing of medical services and its potential effect on medical education. Mr. Lash reported that teaching hospitals in many parts of the country are already being confronted by the reality of price competition in the provision of medical care (e.g., Richmond, where 46% of the area's hospital beds are located in proprietary hospitals). Mr. Lash stated his concerns that a competitive health care environment may threaten the quality of medical care in the United States. He questioned whether teaching hospitals can continue to subsidize medical education, the care of the indigent, and the advancement of technology if forced to compete with the rapidly expanding proprietary hospital corporations. Maintenance of a high-quality faculty and an appropriate patient case mix for the education of students and residents may also be a problem in a competitive health care system. To more effectively cope with the competitive trend, Mr. Lash advocated: 1) development of alternative modes of health care delivery; 2) reorganization of the governance structure utilized by most teaching hospitals; and 3) restructuring of the practice patterns of academic physicians. For additional information on this issue, Mr. Lash recommended an AAMC position paper, "Price Competition in the Health Care Marketplace."

D. Comprehensive Qualifying Examination and Single Route to Licensure Proposals

Dr. August Swanson of the AAMC staff reported that since the CAS Interim Meeting on this issue, opposition has grown to the concept of a single route to licensure as proposed by the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB). In May, the AMA House of Delegates had voted in opposition to the proposed single route to licensure (FLEX I-II). In late June, the AAMC Executive Council adopted two position papers which: 1) opposed the development by the NBME of a Comprehensive Qualifying Examination (for use as FLEX I) to be administered at the interface between undergraduate and graduate medical education, and 2) proposed rigorous examinations (including practical clinical examinations) for graduates of medical schools not accredited by the Liaison Committee on Medical Education seeking to practice medicine in the United States. In September, a committee of the Accreditation Council for Graduate Medical Education made similar recommendations and the full Council is expected to act on these at its February meeting.

In spite of these developments, Dr. Swanson reported that the NBME is apparently pursuing the development of a comprehensive qualifying examination. The FSMB seems similarly determined to institute the FLEX I-II examination sequence but has demurred regarding the timing of FLEX I. Rather than administering the exam at the interface between undergraduate and graduate medical education, it is now proposed that it take place at the end of the first graduate year. Dr. Swanson stated that any further developments on this issue would be reported in the AAMC President's Weekly Activities Report.

E. AAMC General Professional Education of the Physician Project

Dr. Swanson reported that Steven Muller, President of the Johns Hopkins University, would chair an AAMC project on the general professional education of the physician. The project will examine pre-clinical and clinical undergraduate education on the



premise that its purpose is to prepare students for the graduate phase. This is seen as critically important as more and more medical school graduates are entering graduate medical education for specialized professional training. The college preparation for medical school will also be examined.

Dr. Swanson stated that in the near future, medical schools and academic societies will be formally requested to provide their views to the project panel. Medical school faculty and academic societies will also be asked to participate in regional hearings to be held in the AAMC's four regions during 1983.

VI. INFORMATION ITEMS

Distinguished Service Member Nominations

Dr. Freedman noted the nomination of Hiram C. Polk, M.D. and F. Marian Bishop, Ph.D. for distinguished service membership in the AAMC.

VII. INTRODUCTION OF NEW CHAIRMAN

Dr. David M. Brown was installed as Chairman of the CAS. Dr. Brown expressed the Council's appreciation to Dr. Freedman for his contributions as Chairman over the last year.

VIII. ADJOURNMENT

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

## ELECTION OF ACADEMIC SOCIETY MEMBERS

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

American College of Neuropsychopharmacology

American Institute of Ultrasound in Medicine

Both 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. Their applications appear on the following pages.

MEMBERSHIP APPLICATION  
COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: American College of Neuropsychopharmacology

MAILING ADDRESS: 134 Wesley Hall  
Vanderbilt University  
Nashville, TN 37240

PURPOSE: The ACNP was formed in response to need for organization to contain the multiple scientific disciplines attracted to field of neuropsychopharmacology. The objectives are: offer investigators an opportunity to communicate by means of scientific meetings which are held annually; promote scientific study of the effects of drugs on the brain and behavior; promote teaching of principles in this area; and to provide a forum where governmental, academic and pharmaceutical representatives can discuss matters of common concern.

MEMBERSHIP CRITERIA: Membership is limited to highly qualified scientists committed to field of neuropsychopharmacology; applicants are reviewed by Credentials committee for entry.

NUMBER OF MEMBERS: 310 voting members

NUMBER OF FACULTY MEMBERS: 80%

DATE ORGANIZED: 1961

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

1981 1. Constitution & Bylaws

Min.-Dec. 1980 Prog. 1981 2. Program & Minutes of Annual Meeting  
(Dec. 81 minutes not approved at this date)

MEMBERSHIP APPLICATION  
COUNCIL OF ACADEMIC SOCIETIES  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

NAME OF SOCIETY: American Institute of Ultrasound in Medicine

MAILING ADDRESS: 4405 East-West Highway, Suite 504, Bethesda, Maryland 20814

PURPOSE: The AIUM was founded to advance the art and science of ultrasonics in medicine and research. Its activities are educational, literary and scientific. The full potential of this biomedical tool can be achieved only by coordinating the efforts of researchers, clinicians, sonographers and engineers. The AIUM is designed to create a multi-disciplinary scientific approach to the diagnostic uses of sonic energy. The AIUM holds annual national meetings which include educational and scientific sessions, and commercial and scientific exhibits. Meetings generally open with an educational session covering current diagnostic techniques, held in conjunction with the Society of Diagnostic Medical Sonographers. Scientific Sessions consist of the presentation of papers concerned with the medical applications of ultrasound and the interaction of ultrasound with tissue. Workshops are available following presentation of scientific papers. AMA Continuing Medical Education Category I credits are on an hour for hour basis.

MEMBERSHIP CRITERIA: General Members should have an academic degree in science or medicine or related fields and one active year of experience in ultrasound - or - equivalent outstanding experience of two years in the field of ultrasound or any closely related field of medicine, biology, physics, or engineering. Senior Members must demonstrate excellence in various areas such as teaching, research, clinical patient care, etc.

NUMBER OF MEMBERS: 5,000

NUMBER OF FACULTY MEMBERS: 55%

DATE ORGANIZED: 1955

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

August, 1981 1. Constitution & Bylaws

August, 1981 2. Program & Minutes of Annual Meeting

## ELECTION OF MEMBERS TO THE 1982-83 ADMINISTRATIVE BOARD

The 1982 CAS Nominating Committee met by conference call on May 4, 1982 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from that meeting is as follows:

### CHAIRMAN-ELECT

Robert L. Hill, Ph.D.  
Association of Medical School Departments  
of Biochemistry  
Durham, North Carolina

### CLINICAL SCIENCE POSITIONS

Joseph E. Johnson, III, M.D.  
Association of Professors of Medicine  
Winston-Salem, North Carolina

Frank G. Moody, M.D.  
Society of Surgical Chairmen  
Salt Lake City, Utah

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

### BASIC SCIENCE POSITION

\* Lowell M. Greenbaum, Ph.D.  
Association for Medical School Pharmacology  
Augusta, Georgia

Curriculum Vitae forms for candidates appear on the following pages.

- \* To serve on the Board for one year, completing the current term of Dr. Robert Hill should he be elected Chairman-Elect.

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORMName: Robert L. HillPresent Location (School) Duke UniversityCAS Society: Association of Medical Schools, Departments of BiochemistryUndergraduate School: University of KansasGraduate School (with degrees and areas of specialization)(e.g. University  
of Wisconsin 1957-60, Ph.D. 1960, Biochemistry)University of Kansas, 1949-54, Ph.D., 1954, Biochemistry

## Academic Appointments (with dates)

University of Utah, 1954-61 - Instructor to Assoc. Res. ProfessorDuke University, 1961-79 - Associate Professor to Professor and Chairman

## Societies/Affiliations:

American Society of Biological Chemists, Council 1969-78, Secretary1972-75, President, 1976.National Academy of SciencesInstitute of MedicineAmerican Academy of Arts and Sciences

## Honors/Awards:

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Joseph E. Johnson, III, M.D.  
Present Location (School) Bowman Gray School of Medicine of Wake Forest University  
CAS Society: Association of Professors of Medicine  
Undergraduate School: Vanderbilt University  
Degree: B.A. Date: 1951  
Medical School: Vanderbilt Medical School Year Graduated: 1954

Location and Nature of Major Graduate Training:

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

Johns Hopkins, Med. Int. Res. & Chief Res. (Osler Serv.) 1954-61

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

Johns Hopkins Infectious Diseases & Immunol. 1959-60

Board Certification:

Internal Medicine 1962  
(Specialty/Date)

Allergy and Immunology 1974  
(Specialty/Date)

Academic Appointments (With Dates):

Instructor, Asst. Prof. & Asst. Dean, Johns Hopkins 1961-66

Assoc. Prof., Prof. & Chief, Infectious Diseases & Assoc. Dean, Univ. of  
Florida College of Med. 1966-72

Prof. & Chairman, Dept. of Med., Bowman Gray School of Medicine 1972-

Chief of Medicine, NC Baptist Hospital 1972-

Societies/Affiliations:

Inf. Dis. Soc. of America, So. Soc. Clinical Invest., Fellow of Am. Coll. Phys.,

Fellow Amer. Acad. of Allergy, Assn. of Am. Phys., Assn. of Prof. of Med. (Sec.-  
Treas. 1978-81, Pres. 1982-3), Am. Fed. Clin. Res., Am. Clin. & Clima. Assn.,  
Am. Assn. Immunol., Soc. Exp. Biol. & Med., Am. Bd. of Int. Med. (Bd. of Governors &  
Exec. Comm. 1981-83), Fed. Council of Int. Med. (Chairman 1982-83). Residency Rev.

Honors/Awards:

Comm.-Int. Med. (Vice Chairman)

Governor for N.C. Am. College of Phys. (1982- ); Chairman, Scientific Program  
Committee, ACP;

Markle Scholar; Mead-Johnson Scholar (American College of Physicians); Royal

Society of Med. Trav. Fellowship; Alpha Omega Alpha; Phi Beta Kappa; Chairman,

Regional Institutes on Geriatrics in Medical Education, AAMC

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Frank G. Moody, M.D.  
 Present Location (School) University of Utah School of Medicine  
 CAS Society: Society of Surgical Chairmen  
 Undergraduate School: Dartmouth College  
 Degree: B.A. Date: 1953  
 Medical School: Dartmouth Medical, Cornell U Med College Year Graduated: 1956  
(1952-54)

Location and Nature of Major Graduate Training:

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

Internship, Assistant Residency and Resident Surgeon - New York Hospital,  
Cornell Medical Center - 1956-63

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

Advanced Research Fellow - American Heart Association, Fellow - Cardiovascular  
Research Institute, University of California Medical Center, San Francisco -  
1963-65

Board Certification:

American Board of Surgery - 1964, recertified 1980

(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

Clinical Instructor in Surgery, UC San Francisco 1963-65

Assistant Professor of Surgery, UC San Francisco 1965-66

Associate Professor and Chief of GI Surgery, Univ of Alabama 1966-69

Assistant Professor, Physiology & Biophysics, Univ of Alabama 1966-71

Professor of Surgery and Director, GI Division, Univ of Alabama 1969-71

Professor and Chairman, Dept of Surgery, Univ of Utah 1971-1982

Professor and Chairman, Dept of Surgery, Univ of Texas Houston, Jan 1983

Societies/Affiliations:

Amer Coll Surgeons, Amer Gastro Assn, Amer Surg Assn, AAMC-CAS, Collegium Internatl  
Chirurgiae Digestivae - US Section, Intl Biliary Assn, Intl Surgical Group,  
North Pacific Surg Assn, Pan Pacific Surg Assn, Philippine Coll of Surgeons, Salt Lak  
Surgical Society, Society for Surg of the Alimentary Tract, Soc of Clinical  
Surgery, Soc of Surgical Chairmen, Soc of Univ Surgeons, Southern Surg Assn,  
SW Surgical Congress, Surgical Biology Club, Utah State Medical Assn, Western  
Surg Assn

Honors/Awards:

Phi Beta Kappa, Alpha Omega Alpha (faculty)



NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Virginia V. Weldon  
Present Location (School) Washington University School of Medicine  
CAS Society: Endocrine Society/SPR/APS  
Undergraduate School: Smith College  
Degree: A. B. Date: 1957  
Medical School: University of Buffalo School of Medicine Year Graduated: 1962

Location and Nature of Major Graduate Training:

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

Intern & Asst. Resident, Pediatrics, The Johns Hopkins Hospital 1962-64

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

Ped/Endocrinology, The Johns Hopkins University School of Medicine, 1964-

Board Certification:

Pediatrics / 1967  
(Specialty/Date)

Ped. Endocrinology / 1978  
(Specialty/Date)

Academic Appointments (With Dates):

Johns Hopkins: Instructor, Peds. 1967-68. Wash. Univ. in St. Louis: Instructor,  
Peds. 1968-69; Asst. Prof., Peds. 1969-73; Assoc. Prof., Peds. 1973-79; Co-Direct  
Div. of Ped. Endocrinology, 1973-77; Asst. to Vice Chancellor for Med. Affairs,  
for Gov. Relations, 1975-77; Asst. to Vice Chancellor for Med. Affairs, 1977-81;  
Asst. Director, CRC, 1972-78; Prof. of Peds., 1979 - present; Assoc. Vice  
Chancellor for Med. Affairs, 1981 - present.

Societies/Affiliations:

AAMC: CAS Administrative Board, 1978 - present; Executive Council, 1980 - present  
Finance Committee, 1981 - present; ad hoc committee on clinical research training,  
1979; ad hoc committee on compensation for Injured Res. Subjects, 1978 - present.  
Endocrine Society: Public Affairs Committee 1974 - present; Program Committee, 19  
Society for Ped Research: CAS Rep, 1976 - present. Lawson Wilkins Pediatric  
Endocrine Society: Public Affairs Committee, 1974 - present. Amer. Acad. of Peds

Honors/Awards:

1957, Society of the Sigma Xi; 1959, Gibson Anatomical Society; 1962, Univ. of  
Buffalo Sch. of Med: Lamb Award, Merck Award, Mosby Award; 1962, Alpha Omega  
Alpha; 1978, St. Louis Globe - Democrat Woman of Achievement

Name: Lowell Greenbaum, Ph.D.  
Present Location (School) Medical College of Georgia  
CAS Society: American Soc. for Pharmacology and Experimental Therapeutics  
Undergraduate School: City College of New York

Tufts University, Ph.D. 1953, Physiology

Instructor of Physiology, Tufts University, 1953-56

## University Professors, International Society for Biochemical Pharmacology

- 17 -

## LEGISLATIVE UPDATE

The Congress will return in late November at the request of President Reagan for a lame duck session. The President requested the session so that the Congress might complete work on the FY 1983 appropriations bills (see page 19). However, it is likely that other controversial issues will be addressed including:

Animal Research Legislation

NIH Renewal Legislation

Establishment of a Separate Arthritis Institute

Summaries of these issues appear on the following pages.

## FY 1983 APPROPRIATIONS

### The Continuing Resolution for FY 1983

Shortly before recessing in anticipation of the upcoming elections, the Congress enacted yet another stop gap funding measure, P.L. 97-276. The act extends appropriations for the vast bulk of the programs under the auspices of the Department of Health and Human Services (HHS)---including the Health Education Assistance Loan (HEAL) program---at FY 1982 levels until December 17, 1982. Language included in both chambers' version of the CR specified that all activities were to be continued under "current terms and conditions" effectively derailing the Administration's attempt to reduce reimbursement for indirect costs. Although the Senate specified that the NIH was to be treated as a special case, and thus temporarily funded it at a level \$205 million above the President's FY 1983 request of \$3.75 billion, the Office of Management and Budget (OMB) has apparently decided to disregard such instructions and is effectively withholding the anticipated increase.

### The House Funding Bill

The House Appropriations Committee cleared an FY 1983 Labor/HHS/Education bill, H.R. 7205, on September 29---the Senate has yet to engage in similar action. The appended chart depicts the Committee's recommended funding levels.

The House Committee was firm in its dictum that the NIH and ADAMHA continue to fully reimburse indirect costs stating in its report that "the Committee...reached the conclusion that a flat, across the board reduction in one component of cost is not an intelligent or equitable way to deal with them...indirect costs are a legitimate component of the costs incurred in performing biomedical research and should be adequately reimbursed."

The Committee displayed similar resolve on the HEAL program repudiating the proposed \$80 million cap "...since Public Law 97-35 established a limit of \$225 million in the basic statute".

For further information contact Melinda Hatton (202/828-0525).

## APPROPRIATIONS

(in millions)

	<u>FY 1982</u>	<u>President's Request FY 1983</u>	<u>House Subcommittee Allocation FY 1983</u>	<u>Senate Subcommittee Allocation FY 1983</u>	<u>Conference Allocation FY 1983</u>	<u>1st Continuing Resolution FY 1983</u>
<u>NIH</u>						--
NCI	\$ 943.0	955.4	981.4			--
NHLBI	559.6	577.1	620.9			--
NIDR	72.0	74.5	80.3			--
NIADOK	368.2	379.0	408.5			--
NINCDS	265.9	274.5	294.4			--
NIAID	235.9	248.0	276.4			--
NIGMS	335.5	345.6	376.0			--
NICHHD	228.3	233.6	251.6			--
NEI	81.9	84.5	96.1			--
NIEHS	127.4	131.5	138.8			--
NIA	154.3	157.4	162.7			--
RR	184.2	191.0	227.6			--
FIC	9.2	10.1	10.1			--
NLM	45.0	46.0	46.0			--
Director	23.6	24.3	24.7			--
Building, etc.	9.9	17.5	17.5			--
<u>TOTAL</u>	3,841.9	3,748.8	4,004.1			3,954.3
NIH Research Training	(155.8)	(151.7)	(170.3)			(--)
<u>ADAMHA</u>						
<u>NIHM</u>						141.1
Research	141.1	150.0	152.3			15.4
Research Training	15.4	14.4	14.4			42.2
Clinical Training	42.2	--	18.0			
<u>NIDA</u>						41.0
Research	41.0	46.3	47.4			.8
Research Training	.8	.9	.9			2.7
Clinical Training	2.7	--	--			
<u>NIAAA</u>						23.4
Research	23.4	32.9	33.5			1.1
Research Training	1.1	1.1	1.1			.9
Clinical Training	.9	--	--			
<u>HEALTH SERVICES ADMINISTRATION</u>						36.4
National Health Service Corps Scholarship	36.4	11.0	11.0			95.0
NHSC Field Program	95.0	103.4	93.0			
Health Professions Students Loans (HPSLs)	5.6	--	2.0			5.6

	<u>FY 1982</u>	<u>President's Request FY 1983</u>	<u>House Subcommittee Allocation FY 1983</u>	<u>Senate Subcommittee Allocation FY 1983</u>	<u>Conference Allocation FY 1983</u>	<u>1st Continuing Resolution FY 1983</u>
<u>HEALTH SERVICES ADMINISTRATION (cont.)</u>						
Exceptional Need Scholarships	4.7	--	6.5			4.7
Primary Care Block Grant (3 programs) <sup>1</sup>	448.8	416.7	446.2			448.8
Maternal & Child Health Block Grant (9 programs) <sup>2</sup>	373.7	350.0	373.0			373.7
Health Education Assistance Loans (HEAL) -- Credit Limit	200.0	80.0	225.0			200.0
<u>HEALTH RESOURCES ADMINISTRATION</u>						
Family Medicine Training	28.9	22.5	28.9			34.0
Family Medicine Department	7.7	7.0	7.7			7.7
General Internal Medicine and Pediatrics	18.3	11.4	11.4			18.3
Area Health Education Centers	18.2	13.9	17.9			18.2
Disadvantaged Assistance	18.9	17.2	17.2			16.9
Preventive Medicine Residencies	--	1.0	1.0			--
Curriculum Development	--	4.4	--			--
Health Planning	64.4	2.1	defer			64.4
<u>ASSISTANT SECRETARY FOR HEALTH</u>						
National Center for:						
Health Services Research	16.2	16.1	16.1			16.2
Health Statistics	38.2	40.3	40.3			38.2
Preventive Health Block Grant	81.6	82.6	82.6			81.6
ADAMHA Services Block Grant	432.0	432.0	424.0			432.0
<u>OFFICE OF HUMAN DEVELOPMENT SERVICES</u>						
National Institute for Handicapped Research	28.6	28.5	28.6			28.6
<u>VETERANS ADMINISTRATION</u>						
Medical Care	7,101.0	7,495.9	7,512.7	7,493.8	7,510.6	--

	<u>FY 1982</u>	<u>President's Request FY 1983</u>	<u>House Subcommittee Allocation FY 1983</u>	<u>Senate Subcommittee Allocation FY 1983</u>	<u>Conference Allocation FY 1983</u>	<u>1st Continuing Resolution FY 1983</u>
<b><u>VETERANS ADMINISTRATION (cont.)</u></b>						
Medical & Prosthetic Research	140.8	138.0	155.0	150.3	152.7	--
Construction						
Major Projects	372.3	419.4	427.1	409.4	407.4	--
Minor Projects	102.0	192.1	141.7	141.7	141.7	--

\*Based on the Administration's reductions which involved a 4-8% cut plus a \$7 million reduction for the NIH in administrative costs, and includes the transfer of funds from NCI and NIEHS and NIGMS to NCI.

1FY-1983 figures assume inclusion of three new programs, Black Lung, Migrant Health and Family Planning that totalled \$165 million in FY-1982.

2FY-1983 figures assume inclusion of Women, Infant and Children Feeding Program that cost \$900 million in FY-1982.

## ANIMAL RESEARCH LEGISLATION

### Summary of House Bill H.R. 6928

Legislation H.R. 6928, "The Humane Care and Development of Substitutes for Animals in Research Act", sponsored by Representative Doug Walgren (D-PA), has been approved by the full House Science & Technology Committee. At the last moment, Mr. Walgren was dissuaded from appending his proposal to the NIH renewal bill, H.R. 6457, which recently passed the House, in exchange for a commitment from Chairman Henry A. Waxman (D-CA), of the House Subcommittee on Health and the Environment, that the Subcommittee would consider legislation in this area, either in the lame duck session or the new Congress.

The most troublesome provisions of the bill are those making Federal research support contingent upon fulfillment of specified accreditation and assurance requirements.

Accreditation. In terms of accreditation requirements the bill would mandate research entities to achieve compliance with the standards prescribed by the American Association for Accreditation of Laboratory Animal Care (AAALAC) over a ten year period. No funding is authorized to assist institutions in attaining compliance. It should be noted that while approximately 75 medical schools are accredited, 50 are not, nor are 80% of NIH grantee institutions. The Congressional Budget Office has estimated that the cost to research entities would be \$500 million.

Assurances. Essentially, the bill would cast in statute many of the details and policies set forth in the NIH's "Policy on Humane Care and Use of Animals". However, the bill's reach extends beyond these guidelines. Institutions would be required to establish animal studies committees to be comprised of: one veterinarian; one member not affiliated with the institution and "who is primarily responsible for representing community concerns regarding the welfare of the animal subjects"; and no more than three members from the same administrative unit of the grantee institution. The Committee would be mandated to undertake scientific review functions not within its scope of expertise such as the review of research methods and practices in progress and the condition of the animals for the purpose of evaluating compliance with the originally approved protocol and with accepted standards for appropriate treatment and use and ensuring that animal pain and distress are minimized. These judgements have always been made through the national system of peer review.



Also, the Congressional Budget Office has estimated that the cost of reporting requirements of this bill---expenses research entities would have to bear---to be approximately \$65 million a year.

In addition, the assurance requirements would involve two separate "whistle-blowing" procedures:

- Members of the animal studies committee will "be encouraged individually" to notify the Animal and Plant Health Inspection Service of the Department of Agriculture, the granting Federal agency and the accrediting agency of "any unacceptable conditions of animal care, treatment, or use, which have not been reported by the committee as a whole and which have persisted despite notification to the research entity".
- Research entities will be required to inform their employees of these provisions and to instruct them to report any violations to the animal care committee. The bill further provides that no employees will be discriminated against as a result of such reporting.

Development of Non-Animal Testing Methods. The bill includes authority for the now very familiar non-animal testing methods program, although authorization of appropriations have been deleted; instead it is now provided that funding for this program "will be made available by the Secretary by allocation of research resources within the Department of Health and Human Services." Those proposals approved but not funded through other HHS programs, would be considered for funding under the new program by a "Special Advisory Panel" which the bill would establish.

#### Summary of Senate Bill S. 2948

Legislation S. 2948 has also been introduced into the Senate by Senator Robert Dole (R-KA). It is possible that Mr. Dole could try and append this to the Senate NIH renewal bill, S. 2311, if it comes to the floor during the lame duck session.

Mr. Dole's bill is virtually identical to the Walgren proposal with the following exceptions:

- Language directing the non-affiliated member of the animal studies committee to protect any trade secrets of the research entity is included.

- The accreditation requirements of the bill will be held in abeyance depending upon the results of a one-year study by the HHS Secretary on the possible economic impact of mandatory accreditation on research laboratories. Following completion of this study, the Secretary will issue implementation regulations based on the results of the study.

For further information contact Mary McGrane (202/828-0525).

RENEWAL LEGISLATION CONCERNING  
THE NATIONAL INSTITUTES OF HEALTH

Two very different proposals have emerged as a result of the need to renew various expiring NIH authorities. While the authorization ceilings in the House-passed proposal are considerably more generous than in the Senate bill, the former is also weighed down with a new institute and numerous disease specific directives, studies and earmarks; the Senate proposal adopts a considerably more flexible and modest approach.

H.R. 6457, "The Health Research Extension Act of 1982".

The original bill sponsored by Mr. Waxman has undergone substantial expansion and modification in the period between its initial introduction and its passage by the House. The bill renews a variety of expiring NIH authorities at levels approximately 7% above those in the Senate bill.

In addition to the renewals of authority, the bill contains a host of other provisions including:

- The statutory establishment of the NIH as well as the authorities of its Director and specification of many of its functions and operations.
- Extensive revision of an addition to the statutory descriptions of each of the 11 National Institutes as currently embodied in Title IV of the Public Health Service Act. The report accompanying the bill stresses Congressional intent that the NIH no longer rely on its open-ended authority, thus setting the stage for time and dollar limits on each of the institutes.
- Creation of a new National Institute of Arthritis and Musculoskeletal Diseases with the renaming of the residue of the NIAMDKD, the National Institute of Diabetes and Digestive and Kidney Diseases.
- A mandate that the Director of NIH "establish a process for the prompt and appropriate response to information provided the Director respecting scientific fraud...and incidence of violations of the rights of human subjects of research..."
- Statutory provisions concerning peer review of intramural research and extramural contracts.

- A \$3 million set-aside of NIH appropriations to carry out the functions of the National Center for Health Care Technology (NCHCT).
- A mandate for a study to examine the questions surrounding the commercialization of biomedical research.
- The transfer of the National Center for Health Statistics (NCHS) and the National Center for Health Services Research (NCHSR) to the NIH.
- The establishment of an NIH Assistant Director for Prevention and offices to administer and promote such research programs within each of the institutes, together with a requirement for a "prevention plan" for NIH supported research.
- The establishment of a separate line authorization for the cancer research and demonstration centers currently funded under NCI's aggregate appropriation.
- The establishment of an interagency committee on spinal cord regeneration.
- A separate authorization for basic and clinical research on spinal cord regeneration with spending ceilings of \$16, \$18 and \$20 million for FY 1983-1985.
- The establishment of a program of Centers for Research and Demonstration of Health Promotion and Disease Prevention with authorization ceilings of \$10, \$20, and \$25 million for FY 1983-1985.
- A study of the role of diet therapy in the treatment of end stage renal disease to be submitted to the Congress by January 1, 1986; authorization of appropriations of \$1 million for each of the next three years.
- A study by the new arthritis institute to be submitted to the Congress by the end of 1982 on the expansion of research on arthritis and musculoskeletal diseases by and through the Institute.
- A study on the safety and effectiveness of the pertussis vaccine.
- A study of the adequacy and availability of personnel to meet the health care needs of the elderly.

- The establishment of an interagency committee on learning disabilities.
- An ambiguously worded prohibition on fetal research of specified characteristics.
- A directive for the NIH to continue the cystic fibrosis centers.

S. 2311, "The Biomedical Research, Training and Medical Library Assistance Amendments of 1982".

This bill was introduced by Senator Orrin Hatch, Chairman of the Senate Committee on Labor and Human Resources and will most likely go to the floor during the lame duck session.

While the authorization levels are far from adequate, they are, surprisingly, 3% above the administration's FY 1983 budget proposals. In other respects, the statutory provisions are far less intrusive than those embodied in the House proposals.

In addition to the renewal of various expiring authorities, S. 2311 also includes provisions for:

- The establishment of a National Kidney Diseases Advisory Board.
- The repeal of the payback requirement associated with awards under the National Research Service Award Program.
- Reauthorization of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research for the next two years with annual authorization ceilings of \$1.1 million.
- Addressing a number of controversial subjects through reporting requirements. It mandates that the Secretary report procedures to the Congress on:
  - "any activities undertaken...to improve the grant, contracting, accountability, and peer review procedures of the NIH (including the NCI)"; and
  - "all activities of the NIH...relating to preventive medicine and health promotion including the number and type of personnel involved in such activities".

- Requiring the director of each institute to notify the Advisory Boards of the status of any investigation concerning any recipient of a grant or contract unless the office conducting the investigation advises that such disclosure will jeopardize the investigation.
- Mandating that the NIH director establish procedures for the appeal of determinations made by the peer review system.
- Establishing a seven-member "President's Council for the Health Sciences" to develop a "National Health Sciences Plan" to set forth long-term research priorities. This represents a diluted version of the Council proposed in the NIH bill championed by Senator Edward Kennedy in the 96th Congress. The Council has a two year life-span with funding ceilings of \$750,000 for each year. The Report specifies the Committee's intent that the Council: document the extent of duplicative Federal research; identify any underdeveloped areas of research which "show great promise"; and identify and facilitate coordination of research throughout the Federal government.

For further information contact Mary McGrane (202/828-0525).

## ESTABLISHMENT OF SEPARATE INSTITUTES AT NIH

As stated on page 26, the House-passed NIH reauthorization bill would establish a separate institute for the study of arthritis and musculoskeletal diseases. More than 40 Senators have signed on as co-sponsors of S.1939, a bill originally sponsored by Senator Barry Goldwater (R-AZ) to establish a separate arthritis institute. In late August, Senator Orrin Hatch (R-UT) added his name to the list of co-sponsors of S.1939 and it is expected that Senator Goldwater will reintroduce the bill as an amendment to the Hatch NIH reauthorization bill (see page 28). If the Hatch or Goldwater bills are considered during the lame duck session, there is little hope that the establishment of a separate arthritis institute can be blocked. In the event that this legislation is not passed by the Senate and conferenced with the House NIH reauthorization bill, the establishment of a separate arthritis institute would be forestalled.

Proposals to establish separate institutes for diabetes, otolaryngology, pulmonary diseases, and digestive diseases are gaining momentum. In opposing the separate arthritis institute, the academic community has also attempted to convey its alarm at the possibility of additional fragmentation of the NIH into disease-specific institutes. On a positive note, the House NIH reauthorization bill includes a provision for a study of the NIH structure prior to the establishment of any other new institutes and Senator Hatch has indicated his support for such a study.

## CHANGES IN MEDICARE REIMBURSEMENT POLICIES

On October 1, the Health Care Financing Administration (HCFA) published regulations to implement changes in the Medicare program mandated by the recent passage of the Tax Equity and Fiscal Responsibility Act. Of particular concern to faculty:

1. The proposed regulations raise a serious question about the way Medicare fees will be determined for physicians who are paid on a salary basis for professional medical and surgical services provided to individual patients. Under the regulations, Medicare officials view a reasonable fee for a physician's service to be the charges billed and retained by the physician, Section 405.481(d) (2), or the compensation paid to the physician by the hospital or any other entity. Charges billed in excess of personal compensation received are assumed by the regulations to constitute an unnecessary profit that should not be paid. This point of view, that net revenue from fees is inappropriate, could undermine the financial benefits of present practice plans, medical foundations, and hospital group practice arrangements.

Though the proposed regulations refer to the possibility of some exception to compensation-based fees for salaried physicians in teaching hospitals, Section 405.551(b), it may be difficult to retain any exception that clearly pays physicians in teaching hospitals more generously than others. The AAMC has repeatedly taken the positions that (1) all physicians in all hospitals should be paid on the basis of billed charges for services to individual patients unless the physician elects fees determined using his/her compensation and (2) the way in which a properly earned fee is used should not alter the amount of the fee.

2. In hospitals which recover outpatient overhead costs, Medicare reimbursement for physicians' services provided in outpatient departments will be reduced to 60% of the nonspecialist prevailing charge for similar services provided in a private office. The justification for this reduction is that it will provide equity between reimbursement for hospital and office services given the fact that hospitals can bill for clinical overhead which is included in the fee of the office-based physician. Services excluded from the reduction are rural health clinic services, ambulatory surgical services, emergency room services provided to prevent death or serious health impairment, services paid on the basis of compensation-related fees, anesthesia services, and radiology services.

Members of the academic community are attempting to point out the illogic of comparing hospital and private office overhead:

- that the overhead and operating expenses of hospital outpatient departments are significantly greater than those of an office practice if a hospital follows Medicare accounting requirements.



- that the overhead for an emergency department which provides services 24 hours per day is in no way comparable to that of a private office.
- that Medicare cost principles require that residency training costs be allocated to outpatient and emergency overhead.  
(Obviously, these costs are seldom incurred in an office practice.)

Attempts are also being made to apprise HCFA that:

- Outpatient and emergency services in teaching hospitals are provided primarily by specialists. Therefore, HCFA should revise the regulations so that the specialist prevailing charge is paid for services provided by specialists (rather than 60% of the nonspecialist prevailing charge).
- It may be practically impossible to establish criteria for defining services performed to prevent death or serious health impairment.

AAMC RESPONSE TO ENACTMENT OF THE SMALL  
BUSINESS INNOVATION DEVELOPMENT ACT

Despite strenuous opposition by the academic community, "The Small Business Innovation Development Act" was signed into law by the President in July. When fully phased-in (1986), the mandated Small Business Innovation Research (SBIR) program at NIH will be supported by a set-aside of \$40 million. Since the enactment of the law, many members of the academic community have been considering whether it is possible (and advisable) to develop organizations which would be eligible to compete for funds under the SBIR program at NIH. In response to numerous requests for additional information and/or advice, the paper which appears on the following pages was developed by AAMC staff.

**"THE SMALL BUSINESS INNOVATION DEVELOPMENT ACT":  
CONSIDERATION FOR ACADEMIC MEDICAL CENTERS**

On July 22nd, President Reagan signed into law, P.L. 97-219, "The Small Business Innovation Development Act of 1982". This paper is designed to identify issues which must be considered as members of the academic community explore the potential for academic participation in the Small Business Innovation Research (SBIR) programs mandated by the act. No recommendations are offered. Rather, the structure of the SBIR programs is described; the feasibility of academic participation, including some characteristics of eligibility under the definition of small business, is considered; some of the policy considerations involved are discussed; and potential political implications are explored.

**The Structure of SBIR Programs**

"The Small Business Innovation Development Act" mandates, *inter alia*, the establishment of SBIR programs in both NIH and ADAMHA. These R&D award programs, open only to small business concerns, will be supported by set-asides from the extramural R&D funds of each agency that will gradually increase from 0.2 percent in the first year to 1.25% in the fourth and all subsequent years. (By 1986, for the NIH, this will amount to a set-aside of approximately \$40 million). The programs will terminate after six years unless the act is renewed. By statute, each agency's SBIR program is to have three phases: phase one, involving awards made to determine the scientific and technical merit and feasibility of ideas; phase two, involving further development of a limited number of meritorious and feasible phase one awards, with special consideration given to proposals with assured non-Federal capital commitments for the third phase; and phase three involving pursuit of the commercial application of phase two endeavors, principally through use of non-Federal capital, but not excluding the possibility of non-SBIR follow-on Federal contracts.

The Small Business Administration (SBA) is charged with the responsibility for issuing policy directives for the general conduct of SBIR programs. The directives, to be issued by November 19th, will provide for standardized solicitations and funding processes, the latter to cover items such as proposal review, protection of proprietary information, rights in data, and cost principles. However, although charged with the responsibility for issuing such directives, the SBA may leave the writing of regulations up to each agency.

The categories of projects to be included in the SBIR programs will be determined by the individual agencies.

## Feasibility of Academic Participation

Issues regarding the feasibility of academic participation in SBIR programs basically fall into three categories: the creation of small business spin-offs; the establishment of a qualified small business; and academic cooperation with firms receiving SBIR awards. Each is discussed in turn below.

### Spin-offs

The first consideration is whether a university, a medical school, a teaching hospital, or sub-unit of one of these organizations such as a department or division, can itself become a small business concern for the purpose of participating in the SBIR program, or whether it can do so through such devices as the organization of controlled subsidiary entities. The conclusion is straightforward and negative. The law and regulations are quite explicit that, in order to be eligible, the small business must be independently owned and operated. This is not to say however, that academic institutions are precluded from having an interest in an independent small business. The threshold question thus becomes what extent of academic (or other outside) interest eclipses the requirement that eligible small firms be independent. The answer centers on the somewhat murky issue of control and is discussed further below with regard to the establishment of qualified small businesses.

### Establishment of a Qualified Small Business

A member organization might, under certain circumstances, determine that it is in its best interest to encourage and facilitate members of its faculties or staffs to organize an independently owned and operated concern which would be eligible to participate. Such a determination would be based in part on the interests and capabilities of the employee, the coincidence of these capabilities with the programmatic objectives of the federal agencies' SBIR programs, and the conclusion that such an independent organization would, on balance, be in the best interest of the academic institution or hospital.

The organizational requirements for firms eligible for SBIR funds are already substantially set by the Small Business Act and its attendant regulations, since eligibility is limited to small business concerns. While the definition of what constitutes such an entity for purposes of the SBIR program may be refined by future SBA directives, the term is defined in the Small Business Act as follows:

"Sec 3. For the purpose of this Act, a small business concern shall be deemed to be one which is independently owned and operated and which is not dominant in its field of operation. In addition to the foregoing criteria, the Administrator, in making a detailed definition, may use these criteria, among others: Number of employees, and dollar volume of business. Where the number of employees

is used as one of the criteria in making such definition for any of the purposes of this Act, the maximum number of employees that a small business concern may have under the definition shall vary from industry to industry to the extent necessary to reflect differing characteristics of such industries and to take proper account of other relevant factors."

We are informed by the SBA staff that their intention is to use as their principal criterion the number of employees of the organization and to set this standard consistent with that used for government contracts and referred to in the patent regulations, namely, 500 or fewer employees.

The key requirement in the statutory definition is that the concern be independently owned and operated. This standard is the subject of substantial discussion in the regulations. In short, the regulations are designed to assure that the concern is not controlled by an affiliated organization or by a third party. "Every business concern is considered as having one or more parties who directly or indirectly control or have the power to control it. Control may be affirmative or negative and it is immaterial whether it is exercised so long as the power to control exists." The regulations specify that in making such determinations "consideration shall be given to all appropriate factors including common ownership, common management and contractual relations".

Subsequent to these general prescriptions, an array of mechanisms of control is identified and described in detail. Two of the less obvious examples of circumstances where control by another organization might be found are included here for purposes of illustration:

"(b) Common facilities. One concern shares common office space and/or employees and/or other facilities with another concern particularly where such concerns are in the same or related industry or field of operation, or where such concerns were formerly affiliated."

"(vii) Control through contractual relationships--(a) definition of a joint venture for size determination purposes. A joint venture, for size determination purposes is an association of persons or concerns with interest in any degree or proportion by way of contract, express or implied, consorting to engage in and carry out a single business venture, such as a Government contract, for joint profit for which purpose they combine their efforts, property, money, skill, or knowledge, but without creating a corporation or partnership in the legal or technical sense of the term."

The question is sometimes raised as to whether, in order to be a small business, an entity must be organized for profit. The answer is yes. The Small Business Act defines its scope as dealing with "small business concerns" and the regulations define concerns as follows:

"(1) 'Concern' means any business entity organized for profit (even if its ownership is in the hands of a non-profit entity) with a place of business located in the United States and which makes a significant contribution to the U.S. economy through payment of taxes and/or use of American products, material and/or labor, etc. 'Concern' includes but is not limited to an individual, partnership, corporation, joint venture, association, or cooperative. For the purpose of making affiliation findings (see paragraph (a) of this section) any business entity, whether organized for profit or not, and any foreign business entity, i.e., any entity located outside the United States, shall be included.

Finally, it should be pointed out that the Small Business Administration has the duty and the power to determine whether any particular firm, person, corporation, partnership cooperative or other business enterprise is a small business for purposes of the Act. [SBA Sec. 8(b)(6)].

From this discussion, it should be clear that the rules of eligibility are already quite specific, and through additional SBA guidance and agency regulations, they are likely to become more so. Any concern or organization meeting the eligibility criteria is likely to be viewed as a welcome participant in SBIR programs by the agencies, although, as indicated later, congressional reaction may be mixed. The concern's antecedents in an academic institution or hospital should in no sense be viewed as disqualifying.

#### Academic-Small Business Cooperation

While academic medical centers cannot directly pursue awards from SBIR programs, the SBIR programs of the NIH and ADAMHA could provide additional opportunities for university-industry cooperation. The experience of the National Science Foundation SBIR program, on which the legislation is based, is illustrative. The NSF indicates that about one-half of the awards made under their SBIR program involve "coupling" between the small business recipient and a university. The coupling typically takes one of three forms:

- The most frequent involves the use of university scientists and engineers as consultants;
- some small firms have subcontracted parts of their projects to universities; and
- arrangements have also been made for the use of university facilities by SBIR award recipients.

It should be noted that none of these activities is of the nature of a "joint venture" in which initiative and control resides in both parties. While the soon to be issued Small Business Administration policy directives are not likely to explicitly encourage or discourage

university-industry cooperation on SBIR projects, these directives are expected to insure that firms receiving SBIR awards retain primary control over the funded project. Again, the NSF experience is illustrative, although it should not be taken as a determining precedent. The NSF SBIR program requires that, at the time of the award and during the conduct of the proposed research, the principal investor must be primarily employed with the small business; primary employment is defined as 50% of earned income. NSF also requires that the majority of work be performed by the small business recipient. Similar stipulations may well be included in the policy directives or in the regulations governing the NIH and ADAMHA SBIR programs.

Consequently, contrary to what might be implied by a recent Coopers & Lybrand Higher Education Management Alert, opportunities for academic initiative, in SBIR programs (as opposed to cooperation on projects) will probably be limited. The extent of "coupling" that occurs is more likely to be determined by the degree to which small firms seek academic expertise and the responsiveness of schools to such overtures, than by schools initiating offers to collaborate.

### Policy Considerations

A wide array of increasingly familiar policy considerations arise in conjunction with each of the possible avenues for academic participation in SBIR programs. The statement which emerged from the March 1982 Pajaro Dunes Conference (The Chronicle of Higher Education, April 7, 1982, Vol. XXIV, Num. 6) provides one of the more thoughtful discussions of the issues involved in relationships between industry and academe. Briefly, some of the considerations are as follows:

#### Institutional Equity Interest in Small Firms

Institutional interest in corporate research could provide additional revenue for educational endeavors and academically based research activities. However, to the extent that the equity interests of medical schools or universities create a sense of competition between the academic and corporate sectors, the willingness of industry to contribute to academic research efforts may decrease. Further, if the equity interest of the school is in a firm in which members of the school's faculty or staff also have a financial stake, the potential for conflicts of interest to arise (professors as faculty v. professors as employees; professors who are employees--- favored or disfavored---vis a vis professors who are not; professors as employees of competing firms; etc) is likely. The possibility of adverse effects on the morale of the institution is apparent.

#### Extra-Institutional Research Activities

Undoubtedly, some faculty and staff members may show an interest in trying to take advantage of the availability of small business

set-aside funds. To the extent that faculty scientists act as consultants to or accept subcontracts from small business research enterprises, such activity will be within a long standing and fully sanctioned, although not entirely unproblematic, tradition. However, if the participation involves the conduct of research for a company in which the faculty member has a proprietary or equity interest, a panoply of concerns must be considered. (It should be noted here that, as indicated above, it is entirely possible that the policy directives and regulations for SBIR programs will place restrictions on the primary employment of principal investigators of SBIR projects. In that event, the issues noted below will only come into play with regard to the activities of part-time faculty because full-time faculty will be precluded from participating in SBIR programs as main characters).

The potential benefits to academic medical centers of faculty participation in such extra-institutional research include the following:

1. Extra-institutional research creates a vehicle for academically-based scientists to contribute to applied science and the commercial innovative process and consequently to enhance the health and productivity of society.
2. Faculty participation in commercial research fosters university/industry relationships that could:
  - improve employment opportunities for graduate students and post-doctoral fellows;
  - provide access to superior equipment and facilities; and
  - lead to new sources of revenue, such as industrially-sponsored research and the leasing of surplus institutional facilities and equipment.
3. Industrial activity could provide a productive outlet for investigators who would not otherwise be utilizing their full research capability. As such, it could provide a stop-gap for individuals who are primarily academic scientists and yet are temporarily not receiving research support from other sources.
4. The additional compensation earned by faculty in their external activities would supplement that from their academic appointments, making academic employment more competitive with alternative opportunities. This, in turn, would contribute to improving academic institution's ability to recruit and retain investigators.

However, potential conflicts of interest are readily discernible from faculty involvement in extra-institutional research. Problems thus created probably become greater as the fraction of effort devoted



to external activities increases. These appear to include the following:

1. Realignment of loyalty and orientation can weaken institutional integrity.
  - The diversion of energy to commercial activities could lessen attention and commitment to teaching and academic research.
  - The independent sources of support may weaken authority of department chairmen and deans.
2. Conflicts of interest may also distort traditional academic values, and erode the role of the academy as a retreat for independent study.
  - The credibility of reported research results may be impaired when it is disclosed that the investigator has an economic stake in the results.
  - Potential monetary gain from commercial research activities could conceivably prejudice faculty choice of scientific questions pursued in related academically-based research.
  - Scientific progress might be impeded by interference with the free flow of information, should entrepreneurial considerations occasion suppression of, or unreasonable delays in, publication, or discourage open communication about on-going research.

#### Small Business-Sponsored Research

As noted above, although consulting and subcontracting arrangements with industry are more traditional and certainly generally healthy forms of university-industry cooperation, these too are not entirely problem free. While many of the positive considerations raised by extra-institutional research activities such as the enhancement of innovation, and creation of new sources of revenue also hold true for industry-sponsored research, so do some of the more negative concerns such as secrecy and the diversion of energy from academic research.

#### Potential Political Implications

Aside from the considerations discussed above, other possible implications from academic participation in SBIR programs are conceivable. Congressional reaction to faculty participation in SBIR programs is likely to be mixed. While some sponsors of the now enacted set-aside legislation expect and look forward to seeing academic scientists wooed away from their "Ivory Towers", many members of

Congress, particularly those on the House committee with jurisdiction over the NIH and ADAMHA, who actively worked to exempt those agencies, can be expected to view askance the establishment of profit-making research ventures by academic scientists. During the House debate, opponents of the bill predicted that the legislation would cause academic scientists to set up private businesses across the street from their institutions where the same work would be conducted, often by the same people, at a higher cost to government. Further, the "commercialization of academic research" has recently become the subject of on-going congressional investigation. In light of this, and because the controversial nature of the legislation ensures close oversight of its implementation, the role of academic institutions in implementation of the Act is not likely to escape scrutiny and could arouse congressional criticism. Moreover, because of their vocal opposition to the legislation, active pursuit of SBIR funds by academic medical centers or the members of the faculties of such institutions could raise questions on Capitol Hill about the integrity of the voice of academic medicine.

Faculty participation in SBIR programs could be expected to improve significantly both the scientific and technical merit of SBIR proposals. Ironically, this could provide an illusory record of success and improve the chances for renewal of the Act in 1988.

## EVALUATION OF THE PERFORMANCE OF CLINICAL CLERKS

In 1978 the AAMC undertook a project to describe the problems of evaluation of medical student performance in the clinical setting. Through the auspices of the chairmen's organizations of medicine, surgery, family practice, pediatrics, psychiatry, and obstetrics/gynecology, departmental chairmen were asked to identify the member of their department who had primary responsibility for the evaluation of junior medical student clerks. The response was gratifying and the names of over 500 faculty members were provided. These individuals were contacted and asked to submit the evaluation instruments used in their clerkship. More importantly, they were asked to describe their personal views of the problems that arise in the evaluation of the performance of clinical clerks. The following summary of the project's findings and plans for future efforts in this area will be discussed by Xenia Tonesk, Ph.D., Program Director, Personal Characteristics and Skills Assessment, of the Association.

The importance of pursuing improvement in the evaluation of student performance is highlighted by the response of 403 clinical faculty members to the question, "Do evaluation methods and the organization of evaluation data from the clerkships ensure that deficiencies in students' knowledge, skills, and attitudes are identified?" Three hundred and twenty two responded "no" to this question in the spring of 1982.

THE EVALUATION OF CLERKS: PERCEPTIONS OF CLINICAL FACULTY

A Summary of the Issues  
and  
Proposed Actions

Xenia Tonesk, Ph.D.  
Director, Clinical Evaluation Project

Association of American Medical Colleges  
Department of Academic Affairs  
Division of Educational Measurement and Research  
September, 1982

## INTRODUCTION

The evaluation of medical students' performance in their undergraduate clinical years is perhaps the most important responsibility of the faculty. The clinical setting is where students are expected to develop fundamental clinical skills and to begin to apply their knowledge of biomedical science. Students who are not performing well must be identified, steps must be taken to assist them, and, if necessary, some students must be dismissed. This requires that information from a variety of sites and sources be aggregated, weighed and acted upon. Clinical faculty are concerned that they are not effectively accomplishing this responsibility.

In 1978, the Association of American Medical Colleges, through the Clinical Evaluation Project, began to study the problems of the evaluation process from the perspective of clinical faculty. During the course of the project it became clear that there are two distinct sets of factors that exacerbate the situation as it now exists.

There are external factors over which faculty do not have direct or immediate control:

- The reward system encourages clinical faculty as generators of income for institutional support rather than as teachers and evaluators.
- There is a greater demand for faculty involvement in graduate medical education resulting from the expansion of residency training and closer affiliations between medical schools and teaching hospitals. (In 1982, 92% of fourth-year medical school seniors indicated they plan to obtain specialty certification.)
- Greater numbers of faculty and clinical training sites have been pressed into service of educating clerks without appropriate adjustments to the education system, for example: better coordination of the students' clinical experiences at both the departmental and institutional levels; more precise delineation of what faculty are to teach and evaluate; the implementation at the departmental level of institutional guidelines for dealing with problem students.

- The emergence of student "rights" has resulted in faculty's reluctance to record negative evaluations due to fear of legal reprisal. This hesitancy persists in spite of the fact that in numerous instances courts have upheld faculty judgments.

While mindful of the importance of these general institutional considerations, the AAMC study concentrated on identifying and addressing those factors which are more directly controlled by faculty. The purpose of this report\* is to summarize the basic problems identified by the faculty which may be readily remedied and to outline an approach for resolving the problems. The conclusions presented are drawn from two sources:

- Written statements received from 519 clinical services in response to an AAMC inquiry regarding the obstacles to valid, objective and efficient evaluation of clerks. These include 81 responses from internal medicine, 89 from obstetrics-gynecology, 98 from pediatrics, 89 from psychiatry, 103 from surgery and 59 from family medicine.
- Information gathered by AAMC staff from site visits to 14 medical schools.

---

\*A comprehensive background document containing detailed information about the project and the findings is available; inquiries should be directed to Dr. Tonesk at the AAMC.

## FINDINGS

Faculty place too much emphasis on the instruments and methods of evaluation. The primary preoccupation seems to be HOW to evaluate, and much effort is spent scrutinizing evaluation forms, behavioral checklists, and the formats of written and oral examinations. Because of pressures of increased workload and accountability, faculty expect and would welcome the development of the reliable and valid instrument or set of instruments that would resolve their major concerns with evaluation. This expectation is encouraged by evaluation "experts", psychometricians and behavioral scientists who have consistently labeled faculty judgments as unreliable and "soft" and have urged faculty to focus on methods yielding "objective" assessments. Thus, evaluation discussions often include the pros and cons of different numbers of points on rating scales, the merits of an honors/pass/fail system versus letter grades, or whether an oral examination can be made objective. This is misdirected expenditure of effort.

If the situation is to change, if faculty are to assume and execute successfully their appropriate role in the evaluation process, two things must occur:

- Faculty must acknowledge that the primary responsibility for obtaining meaningful evaluations rests with them and that psychometric solutions can not be viewed as substituting for but only as supplementing their judgments.
- Faculty must shift and broaden the perspective from which they view evaluation i.e., the evaluation task must be seen in terms of a system in which many factors determine the optimal evaluation framework for an institution. In other words, faculty must consider WHO evaluates, and WHOM, WHY, WHERE and WHAT they are evaluating prior to considering HOW to evaluate.

### WHO - The Evaluators

All persons with access to evaluative information who can make valuable contributions to the evaluation process should be appropriately identified,

used, and integrated into the system.

- Persons who have first-hand information about clerks should be identified and afforded the opportunity to transmit it formally. For example, junior residents and nurses see behind-the-scenes behaviors not usually observed by senior faculty.
- Persons should not be asked for information that they cannot provide. For example, when attendings serve as the sole evaluators of clerks, they may be recording judgments without the requisite valid information.
- Different evaluation perspectives must be recognized and handled appropriately. The data suggest three kinds:
  - There are important specialty differences in the definition of characteristics to be assessed. For example, the physician-patient relationship has different connotations for surgery, pediatrics, and psychiatry.
  - Evaluators have different expectations with respect to the roles clerks are to assume on a service. On some services, clerks are encouraged to be active participants; on others, passive observers. On some services, adequate history-taking and physical exam skills are assumed; on others, many hours sometimes involving videotaping are spent in teaching such skills.
  - Each evaluator has a personal perspective that enters into any assessment. There are some superb teacher-clinicians who cannot bring themselves to fail anyone; some engrossed researchers who reward knowledge in their specific areas; some junior residents who feel more insecure than the clerks they evaluate, etc.

#### WHOM - The Clerks

In order to be effective and efficient, the evaluation process has to be tailored to different categories of students. Faculty must have confidence in their subjective categorizations of students as a valid first step in the evaluation process and must follow through with the appropriate course of action. Through their unstandardized encounters with students over the years, faculty have accumulated an experiential data base that cannot be replaced by information gathered through existing standardized evaluation instruments.

The collective judgments of faculty permit a ready classification of students into three major categories: superior, adequate and failing.



What occurs is a simple sorting and consensus process: conspicuous students at both extremes make strong and quick impressions on everyone; by default, the rest of the clerks fall into the middle. Conspicuous students are conspicuous precisely because they generate unsolicited information; for the rest, there has to be an active effort to obtain it.

- Faculty identify reliably and handle well the superior student. The evaluation task is one of documenting illustrative specifics, indicating the overall consensus, rewarding, reinforcing and sending the students on to the next opportunity to excel.
- Faculty identify reliably but do not handle well the failing student. The evaluation task is to document the weaknesses, to make explicit the requirements for satisfactory performance, and to specify the criteria by which judgments will be made. If such remediation efforts fail, care must be taken to achieve consensus on dismissals and to accord to the student fair procedures of redress. Fear of legal reprisals undermines the evaluation process with this group.
- Faculty do not identify reliably nor handle well three quite different sub-groups within the heterogenous catch-all category of adequate. Students are rated adequate because: a) they are indeed average and "unremarkable"; b) no one knows them well enough to rate them any other way; or c) the benefit of the doubt invites a positive tilt and allows for inclusion as adequate students who are marginal. Faculty must discriminate among the three sub-groups, verify their conclusions and follow clearly defined steps in each case in order to arrive at a deliberate judgment.

Figure 1 summarizes the different approaches to be used with the categories of students.

#### WHY - The Purpose

Faculty must be aware of their dual role as evaluators in as much as evaluation serves two distinct purposes: competency development and competency assessment.

- Competency development mandates periodic evaluations with feedback to the student as an essential element of the evaluation task. Faculty must know the clerks well enough to identify and highlight strengths and weaknesses in order to pinpoint directions for maximum growth.
- Competency assessment requires the application of specific evaluation standards for acceptable performance. Feedback is an incidental matter.

## WHERE - The Setting

Faculty must not lose sight of the influence of the clinical setting on the evaluation task. For example,

- The ambulatory care setting provides little opportunity for observing clerks with patients over a period of time.
- The busy ward permits only the junior resident to really know the clerk;
- A particular clinical service may provide little educational guidance but much hands-on experience.

## WHAT and HOW - The Content and Methods

It is important to recognize that method of evaluation is inextricably linked with content of evaluation. Accordingly, faculty must affirm their role both in the definition of content and in the selection of methods.

There are different classes\* of content, each with important implications for method.

- Cumulative characteristics are assumed to be augmented at each phase of medical education (e.g., fund of knowledge, technical skills) and are most amenable to evaluation by "objective" assessment instruments. In designing a system of evaluation for such qualities, the task is not so much one of developing instrumentation, but of defining explicitly what is to be assessed, gauging meaningfully the level at which a particular quality is to be manifested at a given stage of the education process, and specifying the rate of expected growth and improvement. The instrumentation need not be reinvented at each institution but merely adapted to the particular clinical setting, department, or medical school.
- Enduring characteristics affect clinical performance but are more difficult to modify in the routine course of the educational process (e.g., sensitivity, ethical behavior, compulsivity). Instrumentation for the assessment of enduring qualities should of necessity be quite different from that applied to cumulative characteristics. Often there are no specific checklists of observable reference points for quantification. What is needed are convenient devices to aid faculty in organizing and communicating their clinical impressions in the most informative way.

---

\*These categories were originally developed by the author for the AAMC position paper "External Examinations for the Evaluation of Medical Education Achievement and for Licensure," (Supplement to the Journal of Medical Education, November, 1981.)

- Latent (inferred) characteristics (e.g., supervisory ability, teaching ability, independent decision-making) require faculty to assess the potential of clerks on dimensions for which little current data in terms of actual behaviors are available at the time. Faculty judgments recorded on communicative evaluation forms are the most appropriate vehicle for evaluation. Even more than in the case of enduring characteristics, any elaborate quantification of latent qualities is apt to belie the tentative basis of faculty judgments.

If content is to be viewed from a progressive, developmental, longitudinal perspective, the faculty must devise effective and acceptable ways of implementing in the evaluation system a cumulative evaluation record for each student so that action judgments are based on information that expands along with the student's progress in the program.

## GENERAL CONCLUSIONS AND RECOMMENDATIONS

Because many interrelated factors comprise the evaluation of students in clinical settings, the variety of information gained as students progress through their clerkships must be integrated through an institutional system that accommodates formal and informal sources of data, different categories of students, different purposes, varying clinical settings, and diverse content. Frequently debated problems of validity and reliability take on a broader meaning when viewed from a systems perspective i.e., the focus becomes one of the validity and reliability of a system rather than that of an instrument. For example, a valid, reliable technique is useless if its results are adulterated and confounded by pooling them with questionable information from a biased source. Likewise, valid information is useless if it is not systematically incorporated into a student's record. Conversely, segmented and isolated information, while it may be valid and reliable is not very meaningful unless placed in context of the totality. The system of evaluation, as a sum, is greater than its parts and should effectively yield more than a simple aggregation of individual sources of information.

An effective evaluation system requires more than the assurance of probity of information. Faculty and students have to share an understanding of the different purposes evaluation serves. The evaluation efforts have to be proportionate to the benefits derived from the results, so that the system is not burdened with unproductive routine. This means that the process may not be uniform across students. The flow of information has to be timely and targeted, allowing for different pathways depending on level, content, and decision alternatives available.

Because of institutional diversity, no two institutions will have identical optimal systems of evaluation. However, the methodology of arriving

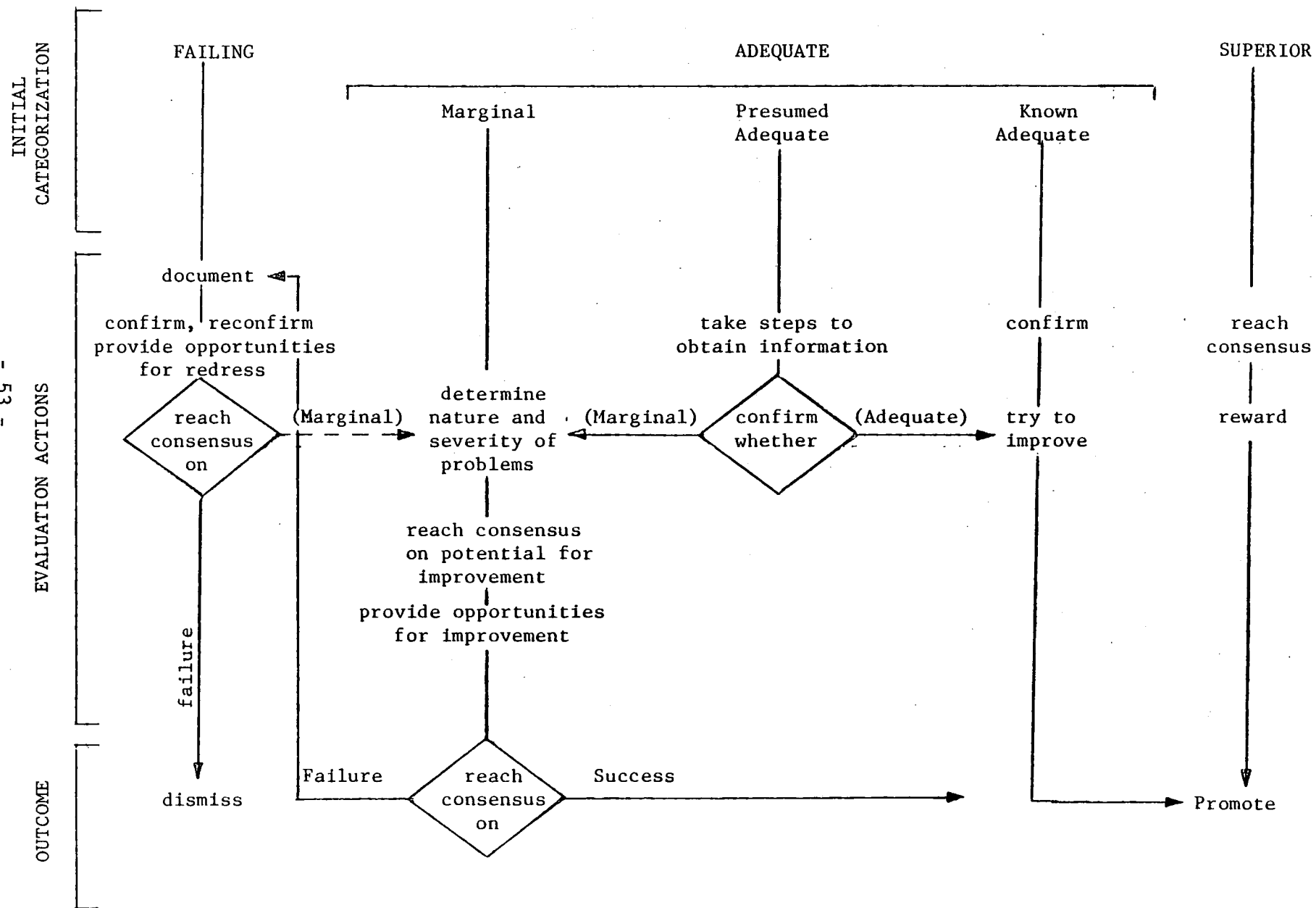
at a delineation of institutional requirements might well be the same or similar.

In order to be able to identify the optimal systems of evaluation for interested medical schools, the AAMC has outlined the following steps:

- The AAMC proposes to develop a set of guidelines of self-study for the diagnostic phase of the institutional evaluation system. Such materials would help schools to examine methodically the various parameters critical for designing the optimal evaluation system.
- The proposed blueprint for self-study will be developed and tested at several institutions of widely varying character.
- A task force will review an inventory of available formal evaluation techniques suitable for particular aspects of evaluation. Once an institution is satisfied through self-study that it has outlined an improved evaluation system, such an evaluation of the state-of-the-art will greatly aid in the implementation of needed improvements.

FIGURE 1

INITIAL CATEGORIZATION OF STUDENTS AND SUBSEQUENT EVALUATION ACTIONS



## DECLINING APPLICANT POOL

The number of applicants to medical school has been on a downward trend since 1976. This trend is expected to continue and probably accelerate during the rest of this decade. Table 1 shows that there were 6,669 (16%) fewer applicants in 1982 than in 1975. Between 1981 and 1982 there was a three percent drop and a five to seven percent drop is forecast for 1983. During this period the number of matriculants has increased by 1,637 (11%) and the applicant/matriculant ratio has decreased from 2.84 to 2.15.

This decrease in competition has not been uniform across the states. Table 2 and Figure 1 show that in 1974 (when the national percent of applicants that were matriculated was 34%) only three states had 50 percent of their resident applicants admitted to a medical school. In 1982 14 states had 50 percent or more admitted. Kansas, at 60 percent, had the largest proportion admitted and Arizona and Hawaii had the smallest at 38 percent. The largest increase in percentage admitted was Rhode Island (25) and there were three states (Alabama, Georgia, and North Dakota) that had a decrease in the proportion of their resident applicants admitted to medical school between 1974 and 1982. This variability in competition for positions by state of residence suggests that medical schools with rigid state residency requirements may now and in the future have a lesser pool of talented applicants from which to select their matriculants.

Female applicants are steadily increasing in number (Table 1). In 1970 they constituted 11 percent of the total. In 1982 they were 33 percent of the pool. Male applicants have been steadily declining in number. Between 1981 and 1982 they decreased by 1,072 while the number of females remained constant. Women now make up 31 percent of the entering class.

Disadvantaged minority applicants have stayed relatively constant at nine percent of the applicants and eight percent of the matriculants through 1981.

Factors that are expected to accelerate the rate of decrease in applicants are (1) a decline in the number of college graduates, (2) the increased financial burden and scarcity of loan funds for medical students, and (3) the wide public discussion of a future physician surplus. Whether a downward trend in the number of positions in medical schools will parallel the applicant trend is conjectural; however, the number of matriculants in 1982 is 97 fewer than in 1981. This is the first year since 1952 that an actual decrease in first year enrollment has occurred.

The Council should discuss the implication of a downward trend in applicants and matriculants to medical school.

APPLICANTS AND NEW ENTRANTS

	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1981</u>	(Approximate) <u>1982</u>
Applicants					
Male	22,253 (89%)	32,728 (77%)	25,436 (70%)	25,054 (68%)	23,982 (67%)
Female	2,734 (11%)	9,575 (23%)	10,664 (30%)	11,673 (32%)	11,652 (33%)
TOTAL	24,987 (100%)	42,303 (100%)	36,100 (100%)	36,727 (100%)	35,634 (100%)
New Entrants					
Male	9,941 (89%)	11,398 (76%)	11,832 (71%)	11,532 (69%)	11,351 (69%)
Female	1,228 (11%)	3,512 (24%)	4,758 (29%)	5,112 (31%)	5,196 (31%)
TOTAL	11,169 (100%)	14,910 (100%)	16,590 (100%)	16,644 (100%)	16,547 (100%)
<u>Applicants</u> <u>New Entrants</u>	2.24	2.84	2.17	2.20	2.15

DISADVANTAGED MINORITY APPLICANTS AND NEW ENTRANTS

	<u>1975</u>		<u>1980</u>		<u>1981</u>	
	<u>Applicants</u>	<u>Entrants</u>	<u>Applicants</u>	<u>Entrants</u>	<u>Applicants</u>	<u>Entrants</u>
Black American	2,288 (5%)*	945 (6%)	2,594 (7%)	1,057 (6%)	2,644 (7%)	1,037 (6%)
Native American	132 (.3%)	57 (.4%)	147 (.4%)	62 (.4%)	160 (.4%)	68 (.4%)
Mexican American	427 (1%)	220 (1%)	449 (1%)	191 (1%)	515 (1%)	281 (2%)
Mainland Puerto Rican	202 (.4%)	86 (.6%)	191 (.5%)	102 (.6%)	222 (.6%)	113 (.7%)
TOTAL	3,049 (7%)	1,308 (8%)	3,381 (9%)	1,412 (8%)	3,541 (9%)	1,499 (9%)

\*percent of total



# MATRICULANTS AS PERCENTAGE OF APPLICANTS

<u>STATE</u>	<u>1974</u>	<u>1980</u>
Alaska	30%	41%
Alabama	45	44
Arkansas	34	43
Arizona	23	38
California	27	42
Colorado	34	41
Connecticut	33	45
Delaware	31	52
Florida	29	43
Georgia	41	39
Hawaii	33	38
Iowa	42	44
Idaho	33	51
Illinois	38	49
Indiana	40	51
Kansas	44	60
Kentucky	38	40
Louisiana	38	47
Massachusetts	28	46
Maryland	35	46
Maine	33	40
Michigan	32	42
Minnesota	38	47
Missouri	31	54
Mississippi	40	49
Montana	30	49
North Carolina	34	44
North Dakota	52	50
Nebraska	38	48
New Hampshire	32	39
New Jersey	31	49
New Mexico	28	40
Nevada	42	43
New York	37	51
Ohio	37	52
Oklahoma	33	43
Oregon	36	39
Pennsylvania	35	49
Rhode Island	34	59
South Carolina	35	54
South Dakota	50	59
Tennessee	23	49
Texas	38	52
Utah	27	44
Virginia	43	44
Vermont	35	49
Washington	33	42
Wisconsin	36	52
West Virginia	37	49
Wyoming	54	58

# Percent of Applicants from each State Admitted to a Medical School

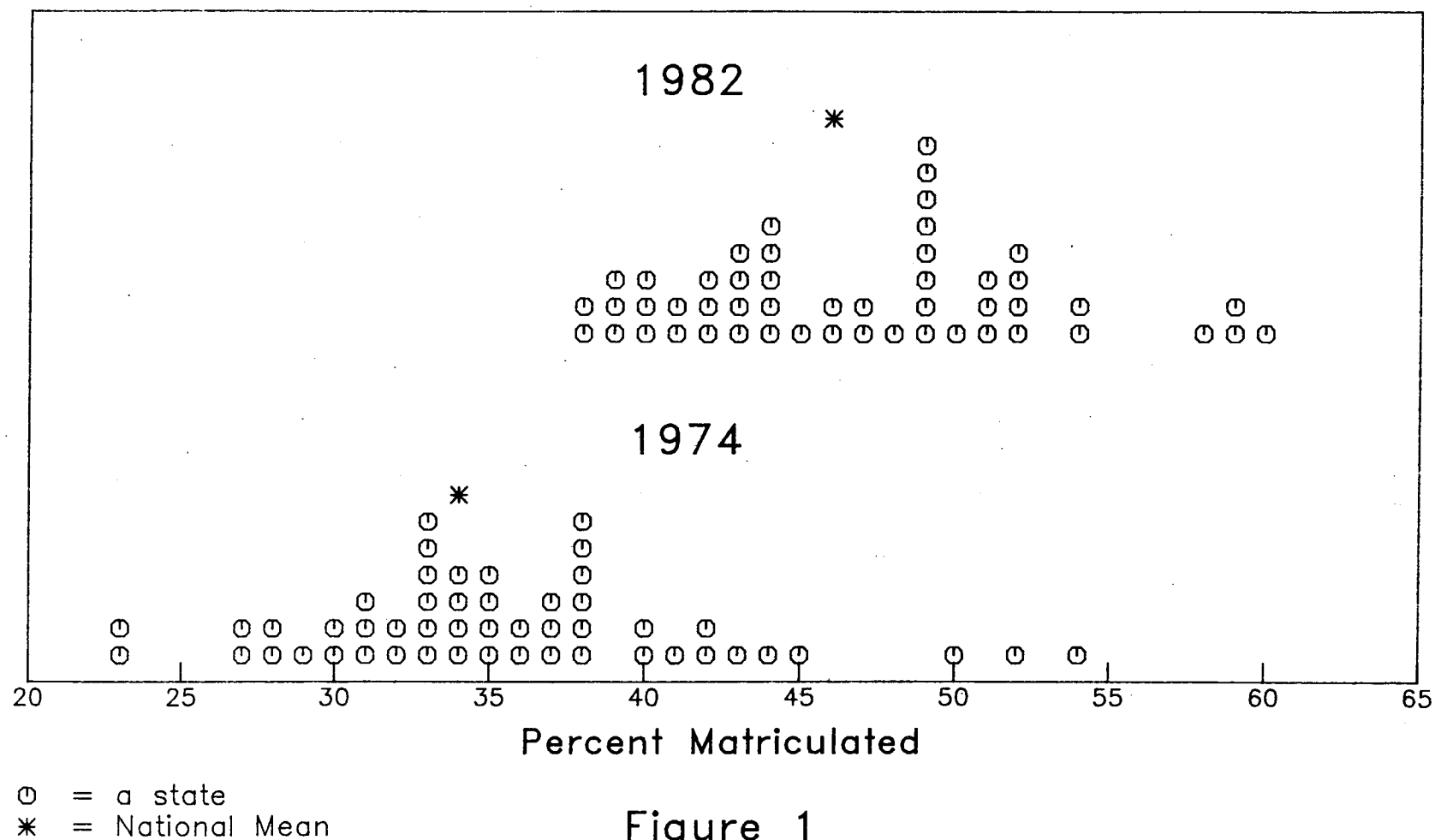
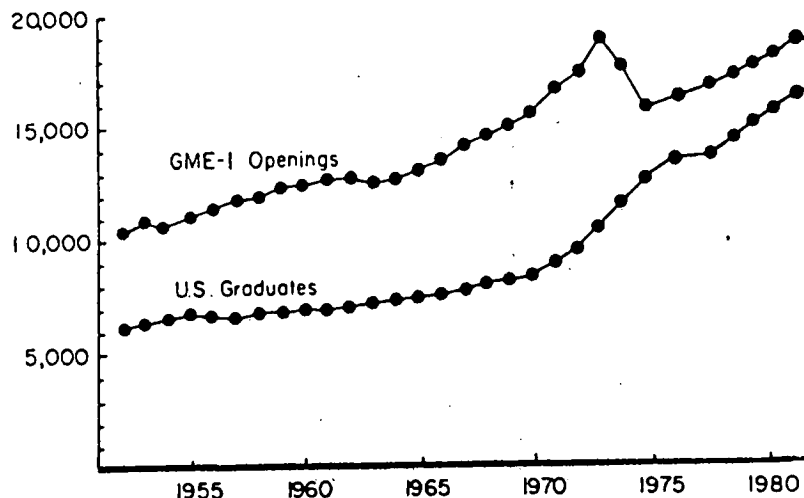


Figure 1

## DECLINING NUMBERS OF GME POSITIONS

The 1982 National Resident Matching Program data indicate a narrowing of the ratio between the number of graduate medical education positions available and the number of graduates from U.S. medical schools (Figure 1).

Figure 1



For the first time in five years the total number of positions offered in the match was less than the previous year (Table 1). The specialties with decreased positions offered were family practice, pediatrics, general surgery, neurosurgery, and all of the support specialties. Internal medicine increased by two percent or 131 positions.

The number of graduates from U.S. schools is steadily increasing (Table 2). The ratio of positions to graduates in 1982 is 1.12. In 1978 the ratio was 1.2. The ratio is even narrower considering the fact that 23 percent of the programs in the Match that offered 2,200 (12 percent) of the total positions did not attract a single U.S. graduate applicant. Subtracting these positions results in a ratio of .99.

In 1982 92.1 percent of the U.S. graduates matched. This compares to 92.8 percent matching in 1981. Competition for positions among graduates of foreign schools increased significantly. Only 75 percent of the Fifth Pathway candidates matched as compared to 82 percent in 1981. U.S. foreign medical graduates matched at the 57 percent level as compared to 67 percent in 1981 and for aliens the percentage fell to 31 percent from 45 percent in 1981.

Jack Graettinger reports that for the first time, several institutions withdrew unfilled positions after the match.

The removal of unmatched positions decreases the effective number of positions listed by programs in NRMP and increases the difficulties of finding places for unmatched students.

With the increasing pressures on cost containment, there is a question whether hospitals will be able or willing to fund additional residency positions and some may even reduce their previous levels.

This trend, should it continue, has serious implications. By 1984 there will be 16,800 U.S. graduates. To maintain this year's ratio of 1:1.12, 18,000 positions will be required. To regain a ratio of 1:1.2, 20,000 positions would be needed.

### Foreign Medical Graduate Competition

There was a dramatic increase in the number of foreign medical graduates in the 1982 match. U.S. citizen FMGs increased from 785 to 1,400 (78%) and alien FMGs increased from 1,731 to 4,000 (167%)(Table 3). However, data from NRMP indicate that these candidates are not displacing U.S. domestic graduates from the programs they aspire to enter. There is a class of programs to which few U.S. graduates are matched. Six states have ten or more hospitals whose programs attract less than one-third of the U.S. graduates needed to fill them (Table 4). New York has the largest number with 39 hospitals offering 586 positions in 113 programs that matched only 70 U.S. graduates (12%). Illinois is second and New Jersey third in this ranking. The aggregate total of 2,242 positions among this class of hospitals and programs represents a sizeable pool of graduate medical education positions. Apparently the quality of the education being provided is considered to be insufficient by U.S. graduates and their faculty advisors.

### Program Accreditation

The ACGME and the RRCs have become increasingly stringent in their requirement that programs meet the General and Special Requirements of the Essentials of Accredited Residencies. In 1981 there were 120 fewer programs than in 1980 (Table 5). (Note: The reduction in pediatric allergy programs is due to the establishment of special competency programs under pediatric and allergy immunology RRCs.) The largest reductions were in pathology and general surgery. While the ACGME and RRCs are to be applauded for demanding adherence to quality standards, the continuing reduction in programs and positions could compound the problem of finding positions for U.S. graduates. It would be preferable to have unacceptable programs upgraded.

A rising number of U.S. graduates, an increasing number of alien and U.S. FMGs, and more stringent application of quality standards by the ACGME and RRC portend that competition for positions in graduate medical education could become intense in the next few years for U.S. domestic graduates.

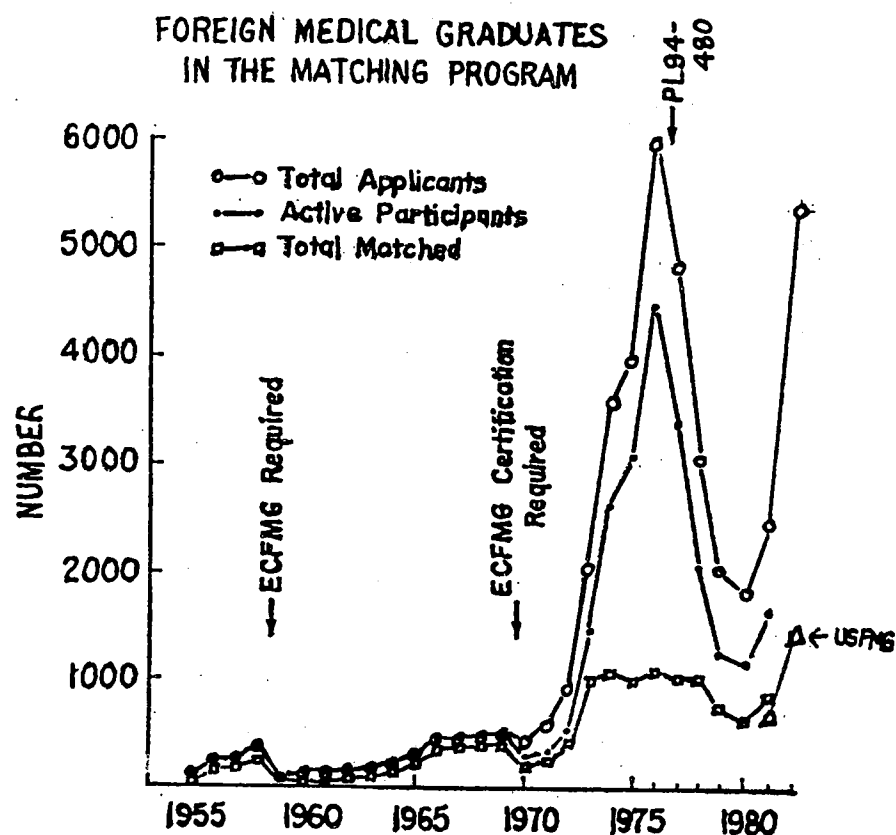
Table 1Positions Offered in Match  
1978-1982

<u>Type of Program</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
Family Practice	2,111	2,251	2,340	2,370	2,362
General Practice	35	19	0	0	0
Internal Medicine	5,571	5,829	6,043	6,129	6,260
Pediatrics	1,776	1,833	1,808	1,833	1,810
Obstetrics	897	966	981	1,008	1,035
subtotal	10,390	10,898	11,172	11,340	11,467
Medical Specialties	1,074	1,074	1,050	1,032	1,031
Dermatology	(8)	(8)	(11)	(8)	(9)
Neurology	(86)	(73)	(74)	(74)	(72)
Ophthalmology	(41)	(27)	(32)	(27)	(28)
Psychiatry	(939)	(966)	(933)	(923)	(922)
General Surgery	2,310	2,393	2,369	2,407	2,340
Surgical Specialties	409	402	434	431	548
Neurosurgery	(37)	(39)	(41)	(45)	(40)
Orthopedics	(242)	(240)	(257)	(250)	(305)
Otolaryngology	(49)	(44)	(46)	(52)	(96)
Urology	(81)	(79)	(90)	(84)	(107)
Support Specialties	1,593	1,623	1,649	1,672	1,564
Anesthesiology	(448)	(466)	(518)	(526)	(507)
Pathology	(582)	(612)	(573)	(574)	(557)
Physical Medicine	(88)	(89)	(116)	(105)	(92)
Dx Radiology	(397)	(373)	(369)	(383)	(336)
Rx Radiology	(78)	(83)	(73)	(84)	(72)
Flexible	1,443	1,434	1,381	1,449	1,343
Total	17,219	17,824	18,055	18,331	18,293

Table 2

	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
U.S. Graduates	14,393	14,966	15,135	15,623	16,300
<u>Positions</u> <u>Graduates</u>	1.20	1.19	1.19	1.17	1.12

Table 3



APPLICANTS			
	1981	1982	Change
US Graduates	15,496	16,000	+ 3%
5th Pathway	456	523	+ 15%
USFMG	785	1,400	+ 78%
Other	687	700	+ 2%
Sub-total			
US-Canadian			
Citizens	17,424	18,623	+ 7%
Alien FMG	1,731	4,000	+167%
Total	19,155	22,623	+ 18%
US-Canad Grads	16,183	16,700	+ 3%
Foreign Grads	2,972	5,923	+ 99%
Total	19,155	22,623	+ 18%

POSITIONS		
1981=18,900		
1982=19,480		
POSITIONS PER APPLICANT		
	1981	1982
US Canad Grad	1.17	1.17
US Citizen	1.08	1.05
All Applicants	0.97	0.86

Note: All 1982 data are approximate

1 x 81

Table 4

HOSPITALS AND PROGRAMS THAT FILLED LESS THAN ONE-THIRD  
OF POSITIONS WITH U.S. GRADUATES IN THE NRMP IN 1982

<u>State</u>	<u>Hospitals</u>	<u>Programs</u>	<u>Positions</u>	<u>U.S.G.</u>	<u>Others</u>
Alabama	3	4	17	4	0
California	5	9	52	13	16
Connecticut	8	12	98	15	42
Delaware	1	1	4	0	0
Dist. Columbia	4	20	76	16	15
Florida	3	3	13	1	4
Georgia	2	3	21	3	0
Illinois	21	67	300	56	134
Indiana	1	1	4	0	0
Iowa	1	3	7	2	1
Kentucky	1	1	6	2	1
Louisiana	3	3	15	1	8
Maryland	6	20	66	6	21
Massachusetts	3	10	46	12	15
Michigan	10	24	123	29	28
Missouri	5	9	51	7	16
Nevada	1	5	26	9	0
New Jersey	20	49	217	32	105
New York	39	113	586	70	295
North Dakota	1	1	8	2	0
Ohio	10	45	201	35	31
Oregon	1	1	1	0	0
Pennsylvania	14	44	211	29	61
Puerto Rico	1	3	18	4	0
Rhode Island	2	4	19	5	2
Tennessee	4	5	23	3	1
Texas	2	2	8	0	6
West Virginia	1	4	13	2	3
Wisconsin	2	2	12	2	0
PAGE TOTAL	175	468	2,242	360 (16%)	805 (36%)

---

Total in Match	700	3,516	18,300	13,053	1,931
Page Total Percent of Match Total	25	13	12	3	42

Table 5

Number of Accredited Residency Programs by Specialty

<u>Specialty</u>	<u>No. of Accredited Programs</u>				
	<u>Oct. 79</u>	<u>June 80</u>	<u>Increase/ Decrease</u>	<u>Sep. 81</u>	<u>Increase/ Decrease</u>
Allergy and Immunology	46	55	+ 9	73	+18
Anesthesiology	163	163		161	- 2
Colon and Rectal Surgery	27	27		26	- 1
Dermatology	97	97		99	+ 2
Dermatopathology	14	18	+ 4	20	+ 2
Family Practice	366	385	+19	385	
Internal Medicine	443	445	+ 2	443	- 2
Neurological Surgery	94	97	+ 3	93	- 4
Neurology	120	121	+ 1	123	+ 2
Nuclear Medicine	89	93	+ 4	93	
Obstetrics/Gynecology	306	306		304	- 2
Ophthalmology	163	160	- 3	155	- 5
Orthopedic Surgery	188	181	- 7	180	- 1
Otolaryngology	117	115	- 2	112	- 3
Pathology	358	359	+ 1	314	-45
Blood Banking	18	23	+ 5	29	+ 6
Forensic Pathology	36	36		35	- 1
Neuropathology	54	57	+ 3	54	- 3
Pediatrics	253	253		245	- 8
Pediatric Allergy	25	19	- 6	0	-19
Pediatric Cardiology	51	51		48	- 3
Physical Medicine and Rehab.	65	64	- 1	65	+ 1
Plastic Surgery	109	106	- 3	105	- 1
Preventive Medicine, General	32	33	+ 1	33	
Aerospace Medicine	3	3		3	
Occupational Medicine	26	26		27	+ 1
Public Health	18	19	+ 1	14	- 5
Psychiatry	232	232		223	- 9
Child Psychiatry	130	130		125	- 5
Radiology, Diagnostic	220	223	+ 3	221	- 2
Radiology, Diagnostic (Nuclear)	30	39	+ 9	43	+ 4
Radiology, Therapeutic	105	105		102	- 3
Surgery	352	352		331	-21
Pediatric Surgery	17	18	+ 1	18	
Thoracic Surgery	101	101		98	- 3
Urology	162	161	- 1	153	- 8
TOTAL	<u>4,630</u>	<u>4,673</u>		<u>4,553</u>	



## 1983 CAS INTERIM MEETING PLANS

The 1983 CAS Interim Meeting will be held in Washington on February 14-15. Following the overwhelming success of the 1982 Interim Meeting, the CAS Administrative Board agreed that a similar session providing the opportunity for interaction between faculty and federal policymakers should be organized for the 1983 meeting.

The meeting will begin on February 14 with a plenary session (see tentative program below). Following this session, CAS Representatives and the invited guests (Congressional staff and Administration officials) will break out into small groups for informal discussion of some of the issues raised during the plenary session. The day's activities will conclude with a cocktail reception.

On February 15, a follow-up session will be held and the meeting will adjourn at approximately 12:00 noon.

### Tentative Program for February 14 Session

James B. Wyngaarden, M.D.  
Director, National Institutes of Health

*Program and Policy Directions of the NIH*

Julius R. Krevans, M.D.  
Chancellor, University of California, San Francisco

*The Collective Impact of Federal Policy Changes  
on the Academic Medical Centers*

Theodore Cooper, M.D.  
Executive Vice President, Upjohn Company

*Political Control and Its Effects on Federal Sponsorship  
of Biomedical and Behavioral Research*

A fourth speaker will discuss the realities of private sector support for basic research.

## GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN PROJECT HEARINGS

The General Professional Education of the Physician Project will enter its second year in January 1983. A status report on the project was distributed to AAMC Annual Meeting Registrants. Over 7,500 copies of the Working Group Charges booklet have been distributed. Eighty-seven medical schools and 20 professorial societies are organizing discussions on the Essential Knowledge, Fundamental Skills, and Personal Qualities, Values, and Attitudes that comprise the general professional education of the physician.

In 1983 the advisory panel will hold hearings in the four AAMC regions. The schedule for these hearings is:

University of California, San Francisco - January 27  
University of Texas, Houston - February 24  
Northwestern University - March 24  
New York Academy of Medicine - May 5

The purpose of the hearings is to provide an opportunity for medical schools, academic societies, and individuals to exchange views with the panel on the changes needed in medical education and college preparation. CAS member societies are urged to inform their members of the hearing schedule. Societies which have agreed to participate in the project are listed on the following page.

### Basic Sciences Professorial Societies

Assn. for the Behavioral Sciences & Medical Education  
Assn. of Medical School Departments of Biochemistry  
Assn. of Medical School Microbiology Chairmen  
Society for Neuroscience  
Assn of Pathology Chairmen, Inc.  
Assn. for Medical School Pharmacology  
Assn. of Chm. of Depts. of Physiology

### Clinical Sciences Professorial Societies

Assn. of Depts. of Family Medicine  
Assn. of Professors of Gynecology & Obstetrics  
Assn of Professors of Medicine  
American Assn. of Neurological Surgeons  
Assn. of University Professors of Neurology  
Assn. of University Professors of Ophthalmology  
Assn. of Academic Depts. of Otolaryngology  
Assn. of Medical School Pediatric Dept. Chairmen  
Assn. of Teachers of Preventive Medicine  
American Assn. of Chairmen of Depts. of Psychiatry  
Society of Chairmen of Academic Radiology Depts.  
Society of Surgical Chairmen  
Thoracic Surgery Directors

## FINANCIAL ASSISTANCE FOR MEDICAL STUDENTS

The overall funding for federal student financial aid programs available to medical students remains cloudy because a final FY 1983 Federal Budget has not been approved. However, the status of some of the principal federal sources of financial support as of October 15, 1982 is described below:

- The Guaranteed Student Loan (GSL) Program has stabilized somewhat. The President's recommendation to bar graduate and professional students from the program received no congressional support. While the Department of Education reports GSL borrowing to be slightly less during FY 1982, it is likely that there will be further, if not virtually annual, attempts to reduce spending for this entitlement program which in academic year 1981-82 supplied 49 percent of all financial aid and 72 percent of all loans to medical students.
- The Health Education Assistance Loan (HEAL) Program (currently at 16.5 percent interest plus a .25 percent insurance premium) continues to grow. The \$48 million borrowed through HEAL in FY 1981 could climb to \$100 million in FY 1982 when data on all HEAL loans for that period are finally compiled. The Department of Health and Human Services presently has commitments for \$170 million to be borrowed from HEAL and the medical schools have projected a need for \$118 million in HEAL funds during FY 1983. The total FY 1983 HEAL requirement for all eligible schools could be near the \$225 million authorized ceiling. The Administration's attempt to cap the program at \$80 million appears to have been overridden by the House Appropriations Committee although some doubt still remains about the ultimate availability of HEAL funds for the coming year. Should this "last resort" loan be denied to significant numbers of students, the result could be catastrophic. In any event, increased HEAL borrowing will mean more rapid escalation of the indebtedness of medical students which for the 83 percent of students with debt reached \$21,051 in 1982.
- The Health Professions Student Loans (HPSL) Program is under attack from proposed regulations published August 31, 1982 by the Department of Health and Human Services aimed at improving HPSL collections. The Association of American Medical Colleges estimates that approximately two thirds of the medical schools could be excluded from the HPSL program if the proposed regulations are not substantially modified. While the recent appropriations for this program have been relatively small, the HPSL funds collected and reloaned at most medical schools are substantial and both are threatened by the regulations. This program and the Exceptional Financial Need (EFN) Scholarship Program are the only two federal student aid programs targeted to "exceptionally needy" students.

## REGIONAL INSTITUTES ON GERIATRICS AND MEDICAL EDUCATION PROJECT

During 1982 the Association of American Medical Colleges has sponsored a project to increase the understanding by officials of medical schools and teaching hospitals of the impact of the aging population on medical education and delivery of care. The project has been directed by a Steering Committee chaired by Joseph E. Johnson, II M.D. chairman of the department of medicine at the Bowman Gray School of Medicine. The Steering Committee developed a discussion draft, "Educational Preparation for Improved Geriatric Care," that served as a stimulus document at four Regional Institutes on Geriatrics and Medical Education held in spring 1982. On the basis of recommendations from those institutes, the Steering Committee is preparing a draft report which will be presented to the Association's Executive Council in January 1983. After the Council has approved the final document, it will be incorporated into the proceedings of the regional institutes and distributed to Association constituents.

The project will be discussed at the AAMC Annual Meeting at a special general session on Tuesday, November 9 from 2:00 - 4:00 p.m.

This effort has been supported by the Pew Memorial Trust and the National Institute on Aging.

## FUTURE MEETING DATES

### AAMC Annual Meeting Dates

- 1983 - November 5-10 (Washington, D.C.)  
CAS Meetings tentatively scheduled for November 6 and 7
- 1984 - October 20-25 (Chicago, Illinois)  
CAS Meetings tentatively scheduled for October 21 and 22
- 1985 - October 26-31 (Washington, D.C.)  
CAS Meetings tentatively scheduled for October 27 and 28
- 1986 - October 25-30 (New Orleans, Louisiana)  
CAS Meetings tentatively scheduled for October 26 and 27

### CAS Interim Meeting Date

- 1983 - February 14-15 (Washington, D.C.)

### CAS Administrative Board Meeting Dates

- January 19-20, 1983
- April 20-21, 1983
- June 29-30, 1983
- September 21-22, 1983