

CAS REGISTRATION INFORMATION

If you wish to attend the October 27-28 CAS meetings, please complete and return the meeting registration form. Please include a check for the registration fee of \$35, made payable to the AAMC, with your registration form. Please return by **October 12 to:**

Ms. Carolyn Demorest
Division of Biomedical Research
AAMC
One Dupont Circle, N.W., #200
Washington, DC 20036

Questions may be directed to Ms. Demorest at (202) 828-0480.

HOTEL RESERVATIONS

The 1985 AAMC Annual Meeting Preliminary Program was mailed in July to all CAS officers and representatives. Those who wish to attend the October 27-28 CAS meeting must register for the AAMC meeting. They should also make hotel reservations using the forms included in the preliminary program. Please keep in mind that accommodations at the co-headquarters hotels (Washington Hilton and Mayflower) are limited and assigned on a first-come, first-served basis. If you wish to stay at either of these hotels, you should return the registration and reservation forms immediately. Additional preliminary forms for the AAMC meeting may be obtained by calling (202) 828-0480.

OTHER AAMC ACTIVITIES OF INTEREST

MONDAY, OCTOBER 28

AAMC PLENARY SESSION
9:00 am-Noon
International Ballroom

The Academic Nature of Medical Education
Harold T. Shapiro, Ph.D.
President, University of Michigan

**Quality, Quantity, and Cost:
Questions in Medicine and Public Policy**
Honorable Bruce Babbitt
Governor of Arizona

**Coggeshall Revisited: A Reaffirmation of
the AAMC's Purpose**
Sherman M. Mellinkoff, M.D.
Dean, UCLA School of Medicine

Final Address by:
Honorable Lowell P. Weicker, Jr.
United States Senate

TUESDAY, OCTOBER 29

AAMC PLENARY SESSION
9:30 am-11:30 am
International Ballroom

**Presentation of AAMC
Research and Flexner Awards**

AAMC Chairman's Address
Richard Janeway, M.D.
Executive Vice President & Dean
Bowman Gray School of Medicine

Inauguration of the John A.D. Cooper Lecture
John A.D. Cooper, M.D.
AAMC President

The Prospects for Science in Medicine
Lewis Thomas, M.D.
President
Memorial Sloan-Kettering Cancer Center



1985 ANNUAL MEETING OF THE COUNCIL OF ACADEMIC SOCIETIES

October 27-28, 1985

Washington Hilton
Washington, D.C.

Program and Registration
Information

1985 ANNUAL MEETING
of the
COUNCIL OF ACADEMIC SOCIETIES

Washington Hilton
Washington, D.C.

PROGRAM

SUNDAY, OCTOBER 27

PLENARY SESSION
1:30 pm-3:00 pm
Lincoln West

**Who Will do Medical Research
in the Future?**

Gordon N. Gill, M.D.
Professor of Medicine
University of California, San Diego
School of Medicine

John W. Littlefield, M.D.
Professor and Chairman of Pediatrics
Johns Hopkins University
School of Medicine

Break
3:00 pm -3:30 pm

PLENARY SESSION
3:30 pm-5:00 pm
Lincoln West

Peer Review: A Crisis of Confidence

Ruth L. Kirschstein, M.D.
Director
National Institute of General Medical
Sciences

Edward N. Brandt, M.D.
Chancellor
University of Maryland at Baltimore
and
Chairman, AAMC Research Policy Committee

CAS COCKTAIL RECEPTION
5:30 pm-7:00 pm
Jefferson West

MONDAY, OCTOBER 28

CAS BUSINESS MEETING
1:30 pm-5:00 pm
Jefferson East

Please Print

1985 CAS ANNUAL MEETING REGISTRATION FORM

Please Return by **October 12**

Name: _____ Society: _____
Address: _____

- ____ I have enclosed my check for \$35.
____ I will attend the CAS Plenary on Sunday, October 27.
____ I will attend the CAS Reception on Sunday, October 27.
____ I will attend the business meeting on Monday, October 28.

CAS ANNUAL MEETING
OCTOBER 27-28, 1985
WASHINGTON HILTON HOTEL
WASHINGTON, DC

MEETING SCHEDULE

SUNDAY, OCTOBER 27

1:30 -- 3:00 p.m. CAS PLENARY SESSION Lincoln West

WHO WILL DO MEDICAL RESEARCH IN
THE FUTURE?

Speakers:

*Gordon N. Gill, M.D.
Professor of Medicine
University of California, San Diego
School of Medicine*

*John W. Littlefield, M.D.
Professor and Chairman of Pediatrics
Johns Hopkins University School of
Medicine*

3:00 -- 3:30 p.m. BREAK

3:30 -- 5:00 p.m. CAS PLENARY SESSION Lincoln West

PEER REVIEW: A CRISIS OF CONFIDENCE

Speakers:

*Ruth L. Kirschstein, M.D.
Director
National Institute of General Medical
Sciences*

*Edward N. Brandt, M.D.
Chancellor
University of Maryland at Baltimore
and
Chairman, AAMC Research Policy Committee*

5:00 p.m. ADJOURNMENT

5:30 -- 7:00 p.m. CAS COCKTAIL RECEPTION Jefferson West

MONDAY, OCTOBER 26

1:30 -- 5:00 p.m. CAS BUSINESS MEETING Jefferson East

5:00 p.m. ADJOURNMENT

COUNCIL OF ACADEMIC SOCIETIES

ANNUAL BUSINESS MEETING

Monday, October 28, 1985
1:30 p.m. - 5:00 p.m.
Washington Hilton Hotel
Jefferson East

AGENDA

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John A. D. Cooper, M.D.

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*David H. Cohen, Ph.D.
Chairman, Nominating Committee*

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*Douglas E. Kelly, Ph.D., Assoc. of Anatomy Chairmen
Co-Chair, CAS-COD Working Group*

*Frank G. Moody, M.D., Society of Surgical Chairmen
Frank C. Wilson, M.D., Am. Orthopaedic Association
Committee Members*

- D. Federal Policy on Graduate Medical Education: Current
Initiatives 55

*Richard Knapp, Ph.D.
Department of Teaching Hospitals, AAMC*

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*Joe D. Coulter, Ph.D., Society for Neuroscience
 Committee Member*

F. AAMC Research Policy Committee 72
*David H. Cohen, Ph.D., Society for Neuroscience
 Committee Member*

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*John A. Gronvall, M.D. Deputy Chief Medical Director
 Veterans Administration*

H. AAMC Faculty Practice Committee 91
*Wilton H. Bunch, M.D., Ph.D., Association of
 Orthopaedic Chairmen
 Committee Member*

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 Research Appropriations FY86
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MINUTES
1984 FALL MEETING
OF THE
COUNCIL OF ACADEMIC SOCIETIES

October 28-29, 1984
Conrad Hilton Hotel
Chicago, Illinois

OCTOBER 28 PLENARY SESSION

"Consideration of the Report of the AAMC Project
Panel on the General Professional Education
of the Physician and College Preparation
for Medicine"

The 1984 Annual Meeting of the Council of Academic Societies began with a Plenary Session entitled "Consideration of the Report of the AAMC Project Panel on the General Professional Education of the Physician and College Preparation for Medicine." CAS members heard two presentations and were then given an opportunity to discuss one of the five major conclusions in small working groups. The CAS then reconvened for a panel discussion led by CAS Administrative Board members.

The first presentation was given by August G. Swanson, M.D., director of the GPEP project. He stated that there were two purposes for the report. The first was to assess present approaches and provide recommendations and strategies for the future. The second was to encourage discussion and thereby involve the entire medical education community. Dr. Swanson outlined the complex and thorough process used to gather the data on which the report was based. He emphasized that the contents of the report were what was reported to the panel and that the report portrays the majority view of panel members. He stated that the GPEP Report was not about the need for curriculum change, physician manpower, future health care of patients, nor a condemnation of past medical education. Rather it supports critical analytical thinking, habits of mind which inspire and challenge students as well as impart information.

Dr. David Alexander, President of Pomona College and a member of the panel, spoke about the link between undergraduate education and medical school. He illustrated the importance of test results to both students and schools, i.e., both tend to measure their success by the level of national test scores. Some professors teach to these tests, and some students study to become good test takers, two shortcuts which circumvent the educational process. Dr. Alexander used an example to show that the sequential nature of the "recommended" background courses needed for medical school functions to require the student to select biology as the undergraduate major and to consider career choices as early as high school. He recommended that education restore direct teaching (as distinct from lecturing), small group discussions, and written papers. He also thought that the improvement of medical school communication with undergraduate pre-med advisors and potential students would facilitate the learning process.

OCTOBER 29 BUSINESS MEETING

I. CALL TO ORDER

The CAS Annual Business Meeting was called to order at 1:30 p.m. Dr. Robert L. Hill, CAS chairman, presided. A total of 59 individuals representing 46 of the 76 member societies were present.

II. PRESIDENT'S REPORT

AAMC President John A.D. Cooper reported on three issues that relate to graduate medical education.

(1) Matching medical students to residency positions: In September 1983, the AAMC Executive Council held a lengthy discussion on the appointment of students to residency programs that begin in the second post-graduate year, e.g., neurology or ophthalmology. Dr. Cooper noted the Association's concern that program directors in these specialties are forcing students to make unreasonably early career decisions and that they are asking medical schools to recommend students for these specialties before the schools have had adequate time to evaluate the students, especially their performance in the clinical rotations. In order to discuss these and other concerns, the AAMC Executive Council met with representatives from five specialties in December 1983. From this meeting came a recommendation that the NRMP establish an advisory board with representatives from all the specialties. The first meeting of this board will be held in April 1985. Dr. Cooper also reviewed a resolution that the AAMC Executive Council adopted in September 1984 proposing that "all internship (PGY-1) and residency (PGY-2 and beyond) programs offered to medical students be offered only through the NRMP." Dr. Cooper stressed the NRMP can accommodate the selection of PGY-1 positions based on acceptance for a specific PGY-2 position; i.e., the student can choose specific and different PGY-1 options for each PGY-2 position for which he or she applies.

(2) Extension of residency training programs: At the 1984 Interim Meeting of the American Board of Medical Specialties (ABMS), AAMC Chairman Robert M. Heyssel introduced a resolution to amend the ABMS by-laws. The AAMC resolution would require that the entire ABMS membership approve any changes in specialty board certification requirements that lengthen the period of residency training or that stipulate requirements that impinge upon training programs of other specialties. Dr. Cooper pointed out that the generic issue in this debate is the autonomy of the specialty certification boards. These boards are able unilaterally to specify educational requirements that often increase the cost of residency training programs. Dr. Cooper noted that concern over the appropriateness of reimbursement payments to fund graduate medical education has focused attention on the actions of the specialty boards. The problem has been accentuated during the past 12 months as five specialty boards have announced their intention to lengthen their residency training programs. The Executive Council of the ABMS has recommended that action on the AAMC resolution be

deferred until an invitational conference can be held on these issues in early 1985.

(3) Financing graduate medical education: Dr. Cooper reviewed the reports of several groups that have been actively studying the issue of who should fund graduate medical education. The first of these groups, the Social Security Advisory Council, has modified an earlier proposed recommendation to eliminate all Medicare payments for graduate medical education. The modified recommendation calls for a careful study of alternative methods for funding GME. A draft report from the Inspector General of the HHS has recommended that Medicare fund only the first year of residency training. After that, the resident and attending physicians would be treated as a "team" receiving one fee not to exceed that paid for the same service in a non-teaching setting. The Congressional Budget Office, in its Report on Federal Spending and Revenue Enhancement Options, has proposed a 25 percent reduction in Medicare payments for direct costs of GME. The report emphasized that the payroll tax should not be used to subsidize medical education because those who benefit will generally earn incomes far higher than the employees who pay the tax. The latest proposal is a bill submitted in October by Senator Durenberger, which suggests that Medicare no longer pay residents' stipends. The bill proposes a separate fund for graduate medical education which would be appropriated on an annual basis by Congress. Ninety percent of the fund would pass through for residency training, while the other 10 percent would, with state matching funds, be used for medical education, at the states' discretion, including training in the allied health professions. The disadvantages of such a system would be that the entire GME system would be at the mercy of the Congressional funding mechanism. Dr. Cooper concluded his remarks by announcing the AAMC Task Force on Financing Graduate Medical Education. The committee held its first meeting in September 1984 in conjunction with the administrative boards of the three councils. The next meeting is scheduled for late November 1984. CAS members on the Task Force include Drs. Frank Moody, Frank Wilson, Louis Sherwood, and Gerald Perkoff.

III. ACTION ITEMS

A. Approval of Minutes

The minutes of the November 6-7, 1983 CAS meeting were approved as submitted.

B. Election of New CAS Members

In accordance with the established procedures, the following societies were recommended to the full council by the CAS Administrative Board for membership in the Council of Academic Societies:

American College of Psychiatrists
American Orthopaedic Association
University Association for Emergency Medicine

ACTION: The above societies were unanimously approved for membership.

Note: On October 30, 1984, by action of the AAMC Assembly, these societies were elected to CAS membership, increasing the number of member societies to 79.

IV. Election of Members to the 1984-85 CAS Administrative Board

The following individuals were nominated to serve on the CAS Administrative Board, to take office at the conclusion of the business meeting:

CHAIRMAN-ELECT

David H. Cohen, Ph.D.
Society for Neuroscience
State University of New York at Stony Brook

BASIC SCIENCE POSITION

Douglas Kelly, Ph.D.
Association of Anatomy Chairmen
University of Southern California School of
Medicine

CLINICAL SCIENCE POSITIONS

A. Everette James, Jr., M.D.
Association of University Radiologists
Society of Chairmen of Academic Radiology
Departments
Vanderbilt University School of Medicine

Frank M. Yatsu, M.D.
American Neurological Association
University of Texas Medical School,
Houston

ACTION: The four individuals listed above were unanimously elected to serve on the CAS Administrative Board.

D. Revision of CAS By-Laws Pertaining to CAS Nominating Committee

On September 13, 1984, the CAS Administrative Board approved the following revision of the CAS By-Laws:

Section V. Committees

1. The Nominating Committee shall be comprised of [seven] a **Chairman and six** members. [The Chairman of the Administrative Board shall be the Chairman of the Nominating Committee and shall vote in the case of a tie. Six individuals (three basic science and three clinical science) **The Chairman, three basic science, and three clinical science members** shall be appointed by the CAS Administrative Board

from among representatives of the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board...

Section IV. Officers

2. Duties of the Chairman. The Chairman shall be the chief administrative officer of the Council and shall preside at all meetings. He shall serve as Chairman of the Administrative Board and shall be an ex officio member of all committees **except the Nominating Committee.** He shall have primary responsibility for...

ACTION: The Council unanimously approved the revision in the CAS By-Laws.

IV. DISCUSSION ITEMS

A. CAS "Future Challenges" Paper

Dr. Hill briefly reviewed the background of this document. An initial draft was prepared on the basis of discussions during the 1984 CAS Spring Meeting, and subsequently was revised by the CAS Administrative Board at its June and September meetings. This paper is intended to examine the past and present organization and activities of the Council and to discuss the future priorities and challenges for medical school faculties. Within this context, Dr. Hill stressed that discussion of the document should be guided by three questions:

- (1) have the major issues facing faculties been identified;
- (2) are there significant issues that have been omitted; and
- (3) are the issues that have been identified germane to the CAS?

Dr. Hill also summarized the results of a survey that was sent to CAS representatives in September. Representatives were asked to assign a high, average, or low priority for CAS to each of 24 possible action items identified within the document. They were also asked to rank the top five items from among those that had been designated as high priority. Fifty-six percent of the societies responded with equal representation from basic science and clinical science societies. The following items were given the highest priority most often:

- (1) Continue advocacy for biomedical research appropriations.
- (2) Continue efforts to increase research training funds.
- (3) Increase institutional priority for education.
- (4) Focus on research faculty development.
- (5) Develop policies for balanced allocation of research funds.

- (6) Examine support for medical student education.
- (7) Support the use of animals in research.

In addition, the following two items received attention from basic scientists:

- (1) Discuss knowledge and skills common to all disciplines.
- (2) Examine faculty involvement in medical student education.

And these items scored well among clinicians:

- (1) Examine relations of faculty practice to academic missions.
- (2) Discuss proposed policies and funding for GME.

A number of additional points were raised during the discussion of this document. It was suggested that the tripartite structure of the Association provides an historical basis for a division of responsibility among the AAMC Councils in regard to the various issues confronting academic medicine. Thus, the CAS has focused primarily on research, with secondary emphasis on post-graduate medical education, while the Council of Deans has concentrated on undergraduate medical education, and the Council of Teaching Hospitals has emphasized patient care. Such a "division of labor" does not preclude a Council from any particular area but serves to establish priorities for each Council.

Other areas of interest included increasing communication and interaction among the CAS member societies, examining the function of the CAS representatives within their societies ("closing the loop"), further developing and implementing the priorities identified, and increasing the political awareness of the member societies. Dr. Hill stressed that the document and survey should not be viewed as final products, but rather as an agenda for a continuing discussion of issues that concern faculties. It was agreed that each CAS representative should take the draft paper and a summary of the priority poll to his society for discussion and comment before an action agenda is developed.

B. Financing Graduate Medical Education

Dr. Elizabeth Short, director of the AAMC Division of Biomedical Research and Faculty Development, reviewed the current situation concerning the funding of graduate medical education (housestaff training) and outlined several recently proposed alternatives. Dr. Short stressed that the figure of \$2 billion that is often cited as the cost of housestaff training actually only covers stipends and benefits for the residents. She also emphasized the increasing resistance to continued funding of this training via patient care revenues.

Among the alternatives currently being discussed are the following:

- (1) A recommendation by the Inspector General of the Department of Health and Human Services that Medicare should pay only for the first year of housestaff training. All other years would be paid out of physician's fees from faculty practice plans.
- (2) Senator Durenberger's bill, which would provide a separate, annual appropriation for Medicare's share of graduate medical education. A provision of this bill would make part of the appropriation available for state matching funds to be used at the state's discretion for medical education, including the allied health professions.
- (3) A proposal presented by Dr. Robert Petersdorf at the September 1984 joint meeting of the Association's Administrative Boards. He proposed that funds be provided for Medicare's portion of approximately 54,000 residency positions (equal to the number of U.S. medical graduates yearly times three years.) All training beyond three years or of numbers of residents exceeding the number of U.S. graduates would come from other sources.
- (4) A six-year medical school package, which would require completion of a residency training program before the medical degree would be awarded. This proposal would keep the first three years of residency training within the medical schools' control.

Dr. Frank Moody, a member of the CAS Administrative Board and also a member of the AAMC Task Force on Financing Graduate Medical Education, stressed the urgency and impact of this problem for all faculty members, even those in the basic sciences. He also led a discussion during which the following points were raised:

- (1) The transfer of graduate medical education costs from Medicare Part A to Part B is already being done in some places. However, this practice carries the concern that additional funds will not be allocated to cover the increased costs to Part B.
- (2) Suburban and for-profit hospitals should be taxed because they benefit from staff trained in teaching hospitals.
- (3) Residency programs that are appended to general medical or surgical programs would be totally unfunded by several of the proposals mentioned above. The representation of these programs on the task force is uncertain, and CAS Council members on the Task Force were urged to represent these concerns.

C. Specialty Certification Requirements

Dr. Joseph Johnson, a member of the CAS Administrative Board, led a discussion of specialty board requirements, particularly the current trend toward lengthening residency training programs. He stressed the necessity of examining these changes in the context of their impact on the limited resources available for graduate medical education and their impact on other specialties (e.g., what effect does the requirement of a first year of broad clinical training before entering a subspecialty have on "provider disciplines" such as general surgery or internal medicine). Although he agreed that increasing general clinical training makes philosophical sense, Dr. Johnson emphasized the need to explore alternative methods of assuring a broad clinical education, e.g., the organization of the third and fourth years of medical school. Council members varied in the degree to which they felt the autonomy of specialty boards should be sacrosanct.

D. Matching Medical Students for Advanced Residency Positions

Dr. Virginia V. Weldon, chairman-elect of the CAS, introduced this issue by describing it as a conflict between what was recommended in the GPEP report (i.e., a broader, more general education for the physician) and a tendency by a number of specialties to ask medical students to commit themselves to a career choice at an unreasonably early point in their undergraduate medical education. In addition, these students are being asked to choose residency positions outside the NRMP system, often forcing the students to participate in two matches. Dr. Weldon also pointed out that one of the suggestions to students who want a residency in a specific program is that they do a junior clerkship at that hospital. This practice often severely encroaches on the student's third year.

One of the points made during the ensuing discussion commented on the other side of asking the students to commit early. This is a situation where a program is so popular that there are more applicants than positions available. The result is that some applicants must remain in another program for a year. For example, some students attempting to enter an orthopaedics program are spending more than one year in general surgery before successfully gaining entrance to an orthopaedics residency.

Comments from several specialties (otolaryngology, ophthalmology) with a separate matching system stressed their belief that the NRMP system could not deliver what the students need--information on admission to a specific residency so that an appropriate first post graduate year can be selected.

Dr. Short summarized the viewpoint of the AAMC Executive Council that students should be chosen for subspecialties as late as possible. In fact, she added, it would be desirable

if all students were chosen for subspecialties after they graduated from medical school.

E. Animals in Research

Dr. John Sherman, AAMC vice president, reviewed the current situation with regard to the activities of "animal rights" groups. He emphasized that the groups opposed to animal research have become better organized, more sophisticated in their approach to legislatures and the media, and much better financed. Dr. Sherman stressed the need to recognize that most groups that favor "animal welfare" believe that all animal research and testing should be eliminated. Although some moderate groups exist, the balance has shifted increasingly toward the "strident types", who, by a variety of means, either directly or indirectly seek to eliminate the availability of animal models in biomedical science.

These groups are more active in all levels of government. Dr. Sherman stated that the greatest threat of restrictions to research is at the local level. The pressures on government agencies and legislatures for action have become stronger in practically every state and locality.

Dr. Sherman encouraged members of the CAS to become more involved in this issue within their institutions as well as their disciplines and societies. He cited a number of opportunities for action. These include a joint effort by the AAMC, the American Medical Association, and the American Physiological Society to coordinate educational activities within the scientific community. This ad hoc committee has reached the point where they will approach a large number of professional societies and volunteer health groups to participate. Dr. Sherman urged professional societies and volunteer health organizations to "come out of the closet" on this issue. He cited the American Cancer Society and the American Heart Association as two groups that have become visibly more active in support of animal research.

E. Legislative Update

David Moore of the AAMC staff provided a brief update on several legislative issues.

- (1) FY 1985 Appropriations -- Congress appropriated \$5,145.9 million for the NIH for FY 1985. This is a 15 percent increase over the FY 1984 appropriation and a 12.7 percent increase over the President's FY 1985 budget request. This appropriation will allow the NIH to fund approximately 6,500 new and competing renewal grants at nearly the full level of direct costs recommended by the peer review study sections. Also included in this appropriation is \$217.9 million for research training under the HRSA program, which will enable the NIH to fund approximately 9,900 trainees with a significant increase in the level of the stipends.

Congress also appropriated \$922.6 million for ADAMHA. Congress was able to restore, and in some cases increase, funds for research and clinical training that the Administration had tried to cut.

- (2) NIH Reauthorization -- The Health Research Extension Act of 1984, S. 540, was sent to President Reagan for his signature on October 19. In addition to a general recodification of the organization of the NIH, the bill established two new institutes (for arthritis and musculoskeletal diseases and for nursing research), redefined the conditions under which fetal research can be performed, created a Biomedical Ethics Board within the legislative branch, established more stringent guidelines governing the care and use of laboratory animals, and created a number of committees and studies.

The Department of Health and Human Services, the White House Office of Science and Technology Policy, and the Office of Management and Budget all recommended that the President veto this bill because of its specific language, which in toto amounts to an attempt by Congress to "micromanage" the NIH. It was stressed that such a veto would in no way effect the current operation of the NIH. Appropriations would continue at the increased levels provided in the Continuing Resolution. As long as Section 301 of the Public Health Act is not repealed or rewritten, the NIH continues to enjoy access to a permanent and open-ended authority for the conduct of research within the Public Health Service by whatever means the Secretary (of HHS) determines.

- (3) "Baby Doe" Legislation -- The Child Abuse Amendments of 1984, which were signed into law in October, contain several provisions that relate to medical treatment for handicapped infants. The first of these "Baby Doe" provisions extends the definition of child abuse to include the "withholding of medically indicated treatment," which is described as the "failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, or medication) which, in the treating physician's ...reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions." However, this definition provides for exceptions when:
- (a) the infant is chronically and irreversibly comatose;
 - (b) the treatment would merely prolong dying, neither ameliorate nor correct the infant's life-threatening conditions, and be futile in terms of the infant's survival; or
 - (c) the treatment would be futile in terms of survival and would be considered inhumane under such circumstances.

As a condition for assistance under this act, the states are required to have programs or procedures within their child protective services systems to respond to reports of medical neglect, including "instances of withholding medically indicated treatment from disabled infants with life-threatening conditions." These programs must provide specifically designated individuals within appropriate health-care facilities to notify the state protective services systems promptly of cases of suspected medical neglect.

- (4) Medicare payment for physicians -- The Deficit Reduction Act of 1984 (Public Law 98-369), which was signed into law on July 18, 1984, initiated numerous changes in domestic spending programs, including Medicare and Medicaid. Among the more significant changes are:
- (a) a 15-month freeze on physicians' fees, with a provision to allow physicians who accept Medicare assignment on all patients to update their customary charge profile (although they will not be paid additional money);
 - (b) a reduction in the annual increase in Medicare DRG prices for technology from 1 percent to .25 percent; and
 - (c) a minimum payment of 85 percent of the prevailing Medicare area fee for professional services by a teaching physician, unless all teaching physicians accept assignment, in which case the minimum is 90 percent of the prevailing area fee.

V. INFORMATION ITEMS

A. Future Meetings

The 1985 Spring Meeting of the Council of Academic Societies will be held March 14-15 in Washington, D.C.

The 1985 Annual Meeting is scheduled for October 26-31 in Washington, D.C. The Annual Meeting of the Council of Academic Societies is tentatively scheduled for October 27-28.

B. Distinguished Service Member

Dr. Frank C. Wilson, former CAS chairman, has been nominated by the CAS for a Distinguished Service Membership in the AAMC.

ELECTION OF ACADEMIC SOCIETY MEMBERS

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

American Society for Clinical Nutrition

American Geriatrics Society

Surgical Infection Society

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: Mr. David Moore

NAME OF SOCIETY: Surgical Infection Society

MAILING ADDRESS: Secretary, Surgical Infection Society
Jonathan L. Meakins, MD, DSc, FRCS(C)
Department of Surgery, McGill University
Royal Victoria Hospital, 687 Pine Avenue West
Montreal, Quebec H3A 1A1, Canada

PURPOSE:

See attached sheet

MEMBERSHIP CRITERIA:

See attached sheet

NUMBER OF MEMBERS: 257

NUMBER OF FACULTY MEMBERS: 229

DATE ORGANIZED: 17 May 1980

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

17 May 1980 1. Constitution & Bylaws

29-30 April 1985 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

 X YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

Section (501) (c) (3)

3. If request for exemption has been made, what is its current status?

 X a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.
Attached

Basil A. Pruitt, Jr.
Basil A. Pruitt, Jr., MD, FACS
(Completed by - please sign)

August 6, 1985
(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: Mr. David Moore

NAME OF SOCIETY: The American Society for Clinical Nutrition

MAILING ADDRESS: 9650 Rockville Pike
Bethesda, MD 20814
USA

PURPOSE: To encourage undergraduate and graduate education and research in human nutrition in health and disease, to provide opportunity for investigators to present and discuss their research in human nutrition, and to provide a journal or journals for publication of meritorious work in experimental and clinical nutrition. A further major aim of the Society is to promote the proper application of the findings of nutrition research to the practice of medicine and related health professions and to provide reliable clinical nutrition information to the professional community and the public.

MEMBERSHIP CRITERIA: Conducted and published meritorious original investigations in clinical nutrition.

NUMBER OF MEMBERS: 630

NUMBER OF FACULTY MEMBERS: -0-

DATE ORGANIZED: September 2, 1959

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

Revised 1984 1. Constitution & Bylaws

May 4-5, 1984 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

X YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501(c)3

3. If request for exemption has been made, what is its current status?

X a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Ant Knight
(Completed by - please sign)

11-1-84
(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: Mr. David Moore

NAME OF SOCIETY: American Geriatrics Society

MAILING ADDRESS: 10 Columbus Circle Room 1470
New York, NY 10019

PURPOSE: See Article II from the American Geriatrics Society, Inc.
By-Laws.

MEMBERSHIP CRITERIA: See back of Membership Brochure

NUMBER OF MEMBERS: 4600 Members

NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: 1942; Incorporated July 17, 1952

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

April 23, 1976 1. Constitution & Bylaws

May 17, 1984 2. Program & Minutes of Annual Meeting

(Continued on Next Page)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501(c) 3

3. If request for exemption has been made, what is its current status?

- a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Erin M. Peddeman
(Completed by + please sign)

24 Sept 1984
(Date)

ELECTION OF MEMBERS TO THE 1986 ADMINISTRATIVE BOARD

The 1985 CAS Nominating Committee met by conference call on May 24, 1985 to develop a slate of nominees for vacant positions of the Administrative Board. The slate of nominees which resulted from that meeting is as follows:

CHAIRMAN-ELECT

Frank G. Moody, M.D.
Society of Surgical Chairmen
University of Texas Medical School,
Houston

BASIC SCIENCE POSITIONS

For a one-year term:

Gordon I. Kaye, Ph.D.
Association of Anatomy Chairmen
Albany Medical College

For a three-year term:

Joe D. Coulter, Ph.D.
Society for Neuroscience
University of Iowa

CLINICAL SCIENCE POSITIONS

For three-year terms:

Gary W. Hunninghake, M.D.
American Federation for Clinical Research
University of Iowa

Ernst R. Jaffe, M.D.
American Society of Hematology
Albert Einstein College of Medicine

Information about the nominees appears on the following pages.

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 Internat
~~Chirurgiae Digestivae - US Section, Intl Biliary Assn, Intl Surgical Group,~~
North Pacific Surg Assn, Pan Pacific Surg Assn, Philippine Coll of Surgeons, Salt Lake
~~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: Gordon I. Kaye
 Present Location (School) Albany Medical College
 CAS Society: American Association of Anatomists; Assn. of Anatomy Chairman
 Undergraduate School: _____

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

Columbia University 1955-1961; A.M., 1957, Ph.D. 1961 zoology;

Anatomy

Academic Appointments (with dates)

Research Associate, Dept. of Anatomy, Columbia Univ., 1961-1963;

Associate in Surgical Pathology, 1963-1966; Assistant Professor of
Surgical Pathology, 1966-1970; Associate Professor of Surgical Pathology,
Columbia Univ. 1970-1976; Alden March Professor & Chairman, Dept. of
Anatomy, Albany Medical College, 1976 & Professor of Pathology

Societies/Affiliations:

American Association of Anatomists; New York Academy of Sciences;
New York Society of Electron Microscopists; Electron Microscopy Society
Society of America; American Society for Cell Biology; The Harvey Society;
Association of Career Scientists of Health Research Council, International
Society for Eye Research; Association of Anatomy Chairman - Pres. 1980-1981

Honors/Awards:

Charles Huebschman Prize; Columbia Univ. 1954
Sigma XI, 1961; Career Scientist of the Health Research Council of NY,
1963-1972; Research Career Developmental Award, NIAMD, NIH, USPHS
Tousimis Prize in Biological Sciences, 1981; Arthur Purdy Stout
Society & Honorary Member, 1985.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Joe Dan Coulter
Present Location (School) University of Iowa
CAS Society: Society for Neuroscience
Undergraduate School: University of Oklahoma

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

- University of Oklahoma Medical Center, Ph.D. 1971, Biological Psychology
- University of Texas Medical Branch, Postdoctoral, 1971-73 - Neuroanatomy
- University of Pisa, Italy, Postdoctoral, 1973-74 - Neurophysiology
- University of Edinburg, Scotland, Postdoctoral, 1974-75 - Neurophysiology

Academic Appointments (with dates)

- Associate Professor (1975-1978) Physiology & Biophysics & Psychiatry & Behavioral Science - University of Texas Medical Branch
- Associate Professor (1978-84) " " "
- Professor (1984-85) " " "
- Professor and Head (1985- present) Anatomy, University of Iowa College of Medicine

Societies/Affiliations:

- Society for Neuroscience (Treasurer 1985- ; Governmental & Public Affairs Committee, 1981-)
- Association of Neuroscience Departments & Programs (Secretary-Treasurer, 1982-)
- American Association of Anatomists
- American Physiological Society
- American Society for Cell Biology

Honors/Awards:

-
-
-
-
-

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NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Gary Hunninghake
Present Location (School) University of Iowa College of Medicine
CAS Society: American Federation for Clinical Research
Undergraduate School: Benedictine College
Degree: B.S. Date: 1968
Medical School: University of Kansas Year Graduated: 1972

Location and Nature of Major Graduate Training:

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

University of Kansas 1972-74

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

NIAID National Institutes of Health 1974-76

Board Certification:

Pulmonary Medicine
(Specialty/Date)

Allergy and Immunology
(Specialty/Date)

Academic Appointments (With Dates):

Professor Medicine University of Iowa 1984-present

Asst. Professor of Medicine University of Iowa 1981-84

Senior Investigator NHLBI/NIH 1977-81

Medical Officer NIAID/NIH 1976-77

Clinical Associate NIAID/NIH 1974-76

Societies/Affiliations:

American Federation for Clinical Research

American Thoracic Society

American College of Allergy

Honors/Awards:

President-Elect, AFCR

President, Allergy and Immunology Assembly, ATS

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Ernst R. Jaffe, M.D.
Present Location (School) Albert Einstein College of Medicine
CAS Society: American Society of Hematology
Undergraduate School: University of Chicago
Degree: Bachelor of Science (Anatomy) Date: 1945
Medical School: University of Chicago Year Graduated: 1948
Also, Master of Science, Pathology
Location and Nature of Major Graduate Training:

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

Intern and Assistant Resident, Presbyterian Hospital, New York

Medical Service 11/48-10/49; 11/49-12/50; 4/53-6/53; 7/54-6/55

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

Research Fellow, Hematology, Albert Einstein College of Medicine,

National Foundation for Infantile Paralysis, 1955-1957

Board Certification:

Internal Medicine 1957
(Specialty/Date)

Hematology 1972
(Specialty/Date)

Academic Appointments (With Dates):

All Albert Einstein College of Medicine.
Instructor, Department of Medicine, 1956-1957

Assistant Professor, Department of Medicine 1957-1962

Associate Professor, Department of Medicine 1962-1969

Professor of Medicine, 1969-Present

Distinguished University Professor of Medicine, 1984-Present

Societies/Affiliations:

American Federation for Clinical Research, American Society for

Clinical Investigation, Association of American Physicians, American

Physiological Society, American Society of Hematology (President, 1983),

International Society of Hematology, Society for Experimental Biology and Medicine,
Honors/Awards: Corresponding (Honorary) Member of Italian Society of Hematology

Phi Beta Kappa Scholastic Honor Society

Alpha Omega Alpha Honor Medical Society

Sigma Xi Honor Scientific Society

Distinguished Service Award, University of Chicago Medical Alumni Association-
1981

COMMENTARY ON THE REPORT ON THE
GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN

In September 1984, the Executive Council adopted a resolution on the GPEP Report that, in part, stated:

It is an extraordinarily useful agenda of issues and the AAMC therefore commends it to its members and to all of those engaged in the enhancement of education for medicine.

We are very hopeful that the report will stimulate a high level of attention and personal commitment by the faculties of member medical schools. In its continuing effort to assist its member schools in improving the quality of physician education the AAMC will create a formal mechanism to review the report and to advise on its use in the development of Association policies and the design of Association programs.

The Administrative Board of the Council of Academic Societies (CAS) appointed a Working Group on the GPEP report in September 1984. At the Annual Meeting in October, representatives to the CAS attended a plenary session on GPEP and participated in small group discussions led by members of the CAS Working Group. As a result of that discussion, the CAS Working Group met to begin formulating a draft commentary on the report. Meanwhile, the Council of Deans (COD) had undertaken a similar effort. The CAS and COD Administrative Boards met for a joint discussion of the GPEP report led by members of the combined working groups in April. Subsequently, the combined CAS-COD Working Group met to further refine the commentary, which was adopted as Association policy by the Executive Council on September 12, 1985.

This commentary has been distributed widely to the medical schools and the academic societies. Each CAS representative should have received a copy by mail and upon registration for the Annual Meeting. A copy of the text of the commentary follows.

Physicians for the Twenty-First Century

Commentary on the GPEP Report

Adopted by
The Executive Council of the
Association of American Medical Colleges
September 12, 1985

Introduction

In September 1984, AAMC's Executive Council commended the GPEP Report⁽¹⁾, *Physicians for the Twenty-First Century*, to its membership⁽²⁾ as an "extraordinarily useful agenda of issues to be considered by each faculty." The report has already stimulated many medical school faculties to undertake reassessments of the educational programs they provide for medical students. It is not prescriptive and serves well as a stimulus for discussion. In its brevity, however, it often lacks the guidelines or the specific solutions that faculties might adopt.

Convinced that medical school deans and faculties would benefit from a commentary on the five conclusions and accompanying recommendations of the GPEP Report, the Administrative Boards of the Council of Deans (COD) and the Council of Academic Societies (CAS) appointed working groups to study the document. The commentary that follows is based upon the deliberations of a combined COD-CAS Working Group from the two boards.

The COD-CAS Working Group believes that most of the conclusions and some of the recommendations of the GPEP Panel, if implemented, would change significantly how medical students are educated in North America. There is no doubt that the steps called for in this implementation would be difficult. How those in medical schools will proceed to capitalize upon the recommendations of this report to enhance the individual educational programs of each school cannot be determined by those external to the programs. Recognizing and appreciating the distinctly unique character of each institution, the COD-CAS Working Group did not fashion a commentary that would presume to preempt the local prerogatives of these complex institutions.

⁽¹⁾ What has come to be known as the "GPEP" Report is the report of AAMC's three-year review of the general professional education of the physician and college preparation for medicine.

⁽²⁾ The membership of the AAMC consists of 127 U.S. medical schools, 400 teaching hospitals, 79 academic societies, and student representatives. Their representation in the Assembly, AAMC's highest legislative body, is through a Council of Deans (COD), Council of Teaching Hospitals (COTH), Council of Academic Societies (CAS), and the Organization of Student Representatives (OSR). Representatives from the three Councils and the OSR comprise the Executive Council, a 24-member board that conducts the AAMC's affairs between the yearly meetings of the Assembly.

The Association of American Medical Colleges was formed in 1876 to raise the standards of medical education. It continues, more than 100 years later, to have as its purpose the advancement of medical education and the Nation's health. In pursuing this purpose, the Association works with many national and international organizations, institutions, and individuals interested in strengthening the quality of medical education at all levels, the search for biomedical knowledge, and the application of these tools to provide effective health care.

This general conclusion calls for a shift in emphasis among the skills, values, and attitudes taught in medical school: a limitation in the volume of factual information medical students are expected to commit to memory; a better enunciation of the levels of knowledge and skills required at each step in medical education; changes in educational settings; and an emphasis on the responsibility of physicians to patients and communities.

The COD-CAS Working Group notes that this conclusion can be and has been interpreted as lessening the relative importance of scientific education, but, after thorough discussion, it is convinced that this was not the intent of the GPEP Panel. Medicine involves the scientific discovery of new knowledge as well as its application to human needs. Therefore, medical education must always project a balance between the scientific and the humanitarian aspects of medicine. Medical students must be well prepared to use the scientific method and to apply analytical skills. They must understand the creation and the flow of knowledge and the relevance of scientific concepts to humane and effective patient care. Understanding and applying the scientific method are essential skills for both basic scientists and clinicians. Students must be educated to function as physicians using current, scientific insight and logic, and they must develop analytical skills that are effective in clinical contexts.

The responsibility for fostering the effective use of the scientific method and analytical skills lies with both basic scientists and clinicians, working together in a coordinated plan. In their scholarly function, involving both education and research, they should seek to preserve balanced proportions of scientific discovery and reasoning, on the one hand, and humanitarian interaction and values, on the other; both should be developed to increasing levels of sophistication and effectiveness throughout medical education.

Early in the project, the GPEP Panel appointed three working groups. One was the Working Group on Essential Knowledge. Its charge was "to consider the knowledge that all students must acquire to provide the foundation for later specialized education and for continued learning throughout their professional careers and to describe approaches faculties might adopt to distinguish this knowledge base from that attained in specialty educational programs or in programs of study leading to advanced degrees in disciplines relevant to medicine." In its final report to the GPEP Panel, the Working Group on Essential Knowledge defined essential knowledge as "that body of information that students need to function successfully and independently at each stage of their education and to continue their development as physicians."

The report of the Working Group on Essential Knowledge, which appears as an appendix to the GPEP Panel's final report published in the *Journal of Medical Education* (November 1984 Part 2), contains the group's definition of "essential knowledge." This definition is not contained in the report of the GPEP Panel that most faculty members have seen. In the latter, "knowledge" is used frequently and the recommendation is made that "levels of knowledge" required must be agreed upon. This has led to an assumption in some quarters that these terms refer to factual information.

The COD-CAS Working Group interprets "essential knowledge" as meaning the concepts and principles necessary for continued intellectual growth and learning all physicians must have before they embark upon their graduate medical education. "Essential knowledge" is not a collection of facts to be memorized as the "core knowledge" all physicians should possess. If understood as concepts, "essential knowledge" and "levels of knowledge" emerge as attainable goals.

Commentary on Conclusion 2

These recommendations relate to baccalaureate education and they call for breadth and rigor in the natural and social sciences and in the humanities. A broad range of activity is recommended to improve writing and communication skills and to assess analytical skills and capabilities for independent learning of students applying to medical school.

The COD-CAS Working Group views many of these recommendations as timely and constructive. It agrees wholeheartedly, for example, that the development of effective writing and other communication skills is essential in students' baccalaureate education. It disagrees, however, with the GPEP proposal that required or recommended science and other courses be limited to core courses required of all undergraduate college students.

While no one argues that an arbitrary quantity of baccalaureate science work ensures adequate preparation for the study of medicine, the COD-CAS Working Group notes that physicians generally must be particularly versed in the biological sciences. Aspirants for medical school must experience and demonstrate an aptitude for science, and the COD-CAS Working Group believes that there is a need for improved quality and sophistication in baccalaureate science education, particularly in biology. The COD-CAS Working Group is convinced that this goal can be accomplished without requiring a biology or chemistry major and without sacrificing educational breadth.

In addition, the COD-CAS Working Group recommends that AAMC provide general advocacy for the achievement of a baccalaureate degree before students enter medical school. The AAMC also might initiate a collaborative effort with other major associations of higher education to achieve the other basic purpose of this recommendation, that is, to foster study in science as an essential ingredient of a broad and thorough education for all baccalaureate students.

Under the same conclusion, the GPEP Report expresses concern regarding current usage of the Medical College Admission Test (MCAT) as a guide in the admissions process. Presently there is no adequate substitute for this test. AAMC needs, however, to conduct continuing reviews of the test to determine its adequacy in meeting the objectives for which it has been devised. To ensure that the MCAT is used appropriately, admissions officers and members of medical school admissions committees must be trained to interpret MCAT scores properly.

Commentary on Conclusion 3

The recommendations of this conclusion are aimed largely at encouraging independent learning by revising the methods of teaching in medical school, particularly during the basic science years. Medical school faculties are urged to set attainable educational objectives, allow more unscheduled time in the curriculum, reduce dependency on lectures as the principal method of teaching, and increase activities that provide students with more opportunities for independent learning and for problem solving.

This section of the GPEP Report has disappointed a number of basic and clinical scientists. They perceive that the GPEP Panel failed to address many aspects of the problems these faculty members currently encounter in the early phases of medical education, particularly the loading of additional courses into the preclinical phase.

The COD-CAS Working Group agrees that it is essential to develop curricular schedules to foster the stated goals. This must be done with an awareness of reasonable student work loads. It is probably not advisable to require more than 20 to 25 hours of organized sessions nor more than five simultaneous courses into this weekly effort.

Curricula should be organized around central concepts that are articulated in "sequential prioritization." In this approach, concepts and principles are the objectives of a given course. The concepts are introduced early in a given discussion, and detailed, factual information is limited to that effectively establishing and illustrating each concept. In sequential prioritization, curriculum designers must carefully determine those courses of study that are fundamental to others, and then arrange the collective offering in a logical, progressive sequence. They also must have reasonable work loads that will lead to students' mastery of basic concepts at a level sufficient to ensure their resourcefulness in continued learning.

The COD-CAS Working Group agrees that independent learning and the development of resourcefulness are important in medical education. In the early years of medical school the basic sciences should foster these capabilities; they should ensure that students understand and can apply fundamental concepts and principles and that they develop a scientific vocabulary. The factual information that students are required to memorize should be limited primarily to these endeavors.

Educational programs based on independent, problem-solving learning by students will increase faculty involvement with students, and the time devoted to teaching by faculty members and learning by students will increase commensurately. Although training faculty members to guide students in independent learning may be difficult and costly initially, long-term costs are unlikely to exceed those of a conventional, lecture-based program. New, sophisticated evaluation mechanisms must be established to augment faculty members' judgments of students' analytical skills.

The recommendations of this conclusion will be best effected when faculties teach fewer courses simultaneously and target each course toward their students' conceptual understanding.

Commentary on Conclusion 4

The recommendations of this conclusion relate largely to the clinical clerkship years. They call for more accurate specification of the clinical knowledge, skills, and values that are required; the adaptation to new clinical settings; the need for faculty guidance and supervision of students during clerkships; the evaluation of students according to specific prescribed criteria; a better integration of basic science and clinical education; and the need to emphasize, during the clinical years, the students' general preparation rather than permitting them to tailor their programs toward gaining specialty residencies.

The COD-CAS Working Group generally agrees with this articulation of the problems and the goals that need to be anticipated in a changing clinical environment: the solutions are difficult, not readily apparent, and need continuous assessment.

The full four years available for medical study prior to the award of the M.D. degree should be dedicated primarily to the broad and thorough general preparation outlined in the GPEP Report and in this commentary. Too early and too intensive a concentration on a specialty is detrimental to an orderly and reasonable pursuit of a general professional education. The timing and process of resident selection should not encroach on effective utilization of all four years of students' general preparation.

The COD-CAS Working Group recommends that those in medical schools responsible for advising students and for judging the educational merit of students' elective programs develop and use explicit criteria for programs in the senior year. Thus, students can accomplish their general professional education protected from the intrusiveness of the recruiting practices of residency program directors.

Commentary on Conclusion 5

The recommendations of this conclusion are aimed at enhancing faculty dedication to and involvement in the educational functions of each medical school. They encourage a better educational organization, a defined budget for education, the establishment of a mentor function between faculty and students, less highly specialized teaching roles, and a high degree of recognition and reward for effective teaching.

This conclusion is perceived to contain many laudable goals. Their achievement will require overcoming serious obstacles inherent in past and present practices of the academic environment.

The COD-CAS Working Group recognizes that a real impediment to educational development in many medical schools has been a lack of direction, focus, and, above all, leadership in curricular design and execution. The COD-CAS Working Group believes that medical school deans and departmental chairmen must provide leadership for the educational functions of their schools and set a tone to ensure that the direction and proper design of programs of medical student education are high priorities. To foster this goal, the COD-CAS Working Group believes it is desirable that the major committee charged with the responsibility for the overall design and coordination of the curriculum should be composed of departmental chairmen. Interdisciplinary committees and individual faculty members, operating in a coordinated fashion, can schedule and implement the curriculum, based on established policies.

Medical school deans and departmental chairmen should continue their efforts to provide visibility, reward, and advancement to outstanding faculty members who are characterized by carrying innovative and effective leadership responsibilities in teaching either basic science or clinical science while, at the same time, maintaining productive programs of quality research. The COD-CAS Working Group makes this recommendation fully recognizing that, in most medical school settings, quality teaching requires firsthand experience with the frontiers of research and/or expanding, innovative avenues of health care delivery.

Full-time faculty members who teach medical students should be engaged in original research or other intellectually challenging, scholarly endeavors. Within each medical school, some faculty members will be more involved with medical students than others. Faculty members who carry major responsibility for the curricular functions of a school should not be exempt from other scholarly requirements. However, competitive pressures on their professional time often will force them to sacrifice the quantity or rate of their research contributions. While sacrificing the quantity or rate of research productivity, they must not sacrifice the quality of their scholarly contributions. These faculty members may encounter difficulty in acquiring support for their research; leaders in institutions and foundations are encouraged to develop mechanisms that will assist them in sustaining research programs having limited rates of productivity.

The COD-CAS Working Group acknowledges that identifying a specific budget for the education of medical students may seem to emphasize the reward for teaching. It believes, however, that defining a budget for the entire cost of the educational program is not feasible for many institutions.

The COD-CAS Working Group agrees that closer relationships between faculty members and students are desirable and that faculties should be encouraged to serve as mentors by working with students in small groups. How much faculties should be expected to encompass in this role, both within and beyond their disciplines, must be resolved. Faculties must know also how their contributions fit within the overall educational plan of their institutions.

The GPEP Report continues to stimulate medical school faculties to reconsider the concepts and principles upon which the education of medical students has been based during this century. The GPEP Panel grounded its conclusions and recommendations on two major assumptions:

1. Biomedical knowledge relevant to the care of patients will continue to expand rapidly.

2. The Nation's health care will increasingly be provided by large organizations.

To prepare physicians who will practice under different and more complex conditions in the twenty-first century will require more than minor tinkering with current curricular patterns. The COD-CAS Working Group has prepared this commentary on the GPEP Report to assist and encourage medical school deans and faculties to reorient their educational programs in a direction that will be consistent with the broad range of demands that physicians will face in the future.

Council of Deans Administrative Board Members

EDWARD J. STEMLER, M.D., *Cochairman*; and Dean, University of Pennsylvania School of Medicine

ARNOLD L. BROWN, M.D., Dean, University of Wisconsin Medical School

JOHN E. CHAPMAN, M.D., Dean, Vanderbilt University School of Medicine

RICHARD H. MOY, M.D., Dean and Provost, Southern Illinois University School of Medicine

RICARDO L. SANCHEZ, M.D., M.P.H., Chairperson, Organization of Student Representatives; and First-Year Resident in Medicine, Cambridge Hospital, Boston, Massachusetts

Council of Academic Societies Administrative Board Members

DOUGLAS E. KELLY, PH.D., *Cochairman*; Representative, Association of Anatomy Chairmen; and Chairman, Department of Anatomy and Cell Biology, University of Southern California School of Medicine

PHILIP C. ANDERSON, M.D., Representative, Association of Professors of Dermatology, Inc.; and Chairman, Department of Dermatology, University of Missouri, Columbia, School of Medicine

DAVID H. COHEN, PH.D., Representative, Society for Neuroscience; and Professor of Neurobiology, State University of New York, Stony Brook, School of Medicine

JACK L. KOSTYO, PH.D., Representative, American Physiological Society; and Chairman, Department of Physiology, University of Michigan Medical School

FRANK G. MOODY, M.D., Representative, Society of Surgical Chairmen; and Chairman, Department of Surgery, University of Texas, Houston, Medical School

INVESTOR OWNED TEACHING HOSPITAL PARTICIPATION IN THE
COUNCIL OF TEACHING HOSPITALS

Under the current rules for determining membership in the Council of Teaching Hospitals, a hospital must qualify as a public hospital or a not-for-profit institution. Thus, hospitals owned or leased by investor owned corporations are excluded from membership in COTH. Hospitals managed by an investor owned corporation are eligible to continue membership.

Participation of for-profit teaching hospitals was discussed at the COTH Spring Meeting in Baltimore in May 1984, the October 1984 Annual Meeting in Chicago, and a variety of other forums. In addition, the Administrative Board of the Council of Teaching Hospitals has reviewed and analyzed all aspects of the debate over this issue.

Arguments in opposition to COTH membership for investor owned hospitals have been presented as follows:

- Participation of investor owned hospitals would dilute the ability of the organization to develop the type of public perception necessary for effective advocacy in public policy forums;
- Inviting investor owned hospitals to participate would be one more step toward legitimizing them as an acceptable and productive component of the health care industry;
- One of the objectives of COTH is information and data sharing among member hospitals. Investor owned hospitals are reluctant to share basic data and information, particularly concerning financial matters;
- Investor owned hospitals have not demonstrated a long term commitment to medical education and research;
- The basic objectives and mission of for-profit corporations command the allegiance of investor owned hospitals to corporate goals;
- Inviting investor owned hospital participation could be a very divisive decision at this point since there is not a clear consensus in the COTH constituency.

Arguments in support of investor owned hospital participation in COTH have been set forth as follows:

- If investor owned hospitals are not invited to participate, another organization could develop representing teaching hospitals;
- The principal teaching hospitals (Humana Hospital University and St. Joseph Hospital in Omaha) at which two medical schools conduct their undergraduate medical education programs are not

eligible for membership. In addition, the number of medical school affiliated teaching hospitals owned by investor owned corporation is growing;

- An open dialogue with investor owned hospitals would be beneficial to COTH/AAMC members;
- Representation in COTH should stand for commitment to education. If investor owned hospitals illustrate this commitment and judged to meet COTH membership requirements, they should be admitted as institutional members;
- If a hospital supports the COTH/AAMC goals and is interested in participation, it should be given the opportunity to do so.

In view of the above, the Administrative Board of the Council of Teaching Hospitals recommended to the Executive Council in September 1985 that:

The Executive Council recommend that the AAMC Assembly ratify the following amendment to Article I of AAMC Bylaws for the purpose of permitting investor owned hospitals to join or remain as members of the Council of Teaching Hospitals provided they otherwise meet membership requirements that apply to all other hospitals:

A. Section 1. Shall be amended to read as follows (current language of Section to be deleted is indicated by strike through):

Section 1. There shall be the following classes of membership: ~~each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:~~

- A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.
- B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.
- C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.

- D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.
- E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.
- F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.
- G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.
- H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.
- I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

B. A new Section 2. shall be inserted to read as follows (language which materially changes the text of the previous Section 1 is set out in bold elite):

Section 2. Members shall meet the qualifications set forth in the Articles of Incorporation, these Bylaws and other criteria established by the Executive Council for the various classes of members. Except that class H. Teaching Hospitals may include as voting members organizations not so described, each member that has the right to vote shall be (a) an organization described in Section 501(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal Tax laws), and (b) an organization described in Section 509(a)(1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal Tax laws).

C. Existing Sections 2 through 5 shall be renumbered 3 through 6 respectively for conformity.

This modification of the AAMC Bylaws will be voted at the AAMC Assembly on Tuesday, October 29, 1985. Ratification of this recommended change requires approval of two-thirds of those members of the Assembly present and voting.

AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

The AAMC Committee on Financing Graduate Medical Education met several times in late 1984 and early 1985 under the pressure of increasingly strong indications that the Congress would act to restrict Medicare direct graduate medical education payments as part of its attempt to reduce Medicare-Medicaid spending. The Committee identified several key policy questions and formulated an agenda of issues document, which was distributed to the individual AAMC councils at their respective Spring meetings (Attachment A). At these meetings, the Committee polled the councils with regard to three of these issues, price competition, funding for FMGs, and the length of graduate training which Medicare funds should support. The results of this poll are included (Attachment B).

In preparation for testifying on S. 1158 before the Subcommittee on Health of the Senate Finance Committee on June 3, 1985, the Executive Committee of the AAMC, after consultation with the members of the Committee on Financing Graduate Medical Education, made the recommendations listed in Attachment C. In regard to the specific issue of the length of graduate training to be supported by Medicare payments, the Association raised concerns about several of the attempts under discussion to limit paying for training, and pointed out that, if it should prove necessary to limit this support, that the most rational approach would be to limit it at the point of initial board eligibility (Attachment D). The Association testimony on this issue proved to be controversial among various academic disciplines, and the issue of limiting the numbers of years of graduate medical education that Medicare would support was discussed at both the June meeting of the administrative boards and the subsequent Committee on Financing GME meeting in July. The Committee has not yet concluded its deliberations on this and a number of other issues. The CAS representatives on the Committee will report on the current status of these discussions.



**association of american
medical colleges**

ATTACHMENT A

**AAMC COMMITTEE ON
FINANCING GRADUATE MEDICAL EDUCATION**

Statement of Issues

March, 1985

In the last five years, the AAMC has completed comprehensive reviews of both graduate and undergraduate medical education.* Among the common themes of these reports is the conclusion that a contemporary medical education requires completion of both medical school and residency training in order to be prepared for independent medical practice. Medical schools provide the general professional education which is the foundation of all medical practice. Residency training or graduate medical education provides the formal clinical education that develops the skills and experience necessary for independent practice. Residency programs are accredited by the Residency Review Committees under the supervision of the Accreditation Council for Graduate Medical Education.

Graduate medical education is not focused on the university campus. It takes place primarily in teaching hospitals. Residents, working under supervision, learn clinical medicine by hands-on participation in the care of hospital patients. Patients are being treated and residents are being trained through the same activities. In effect, both products -- patient care and education -- are being simultaneously, or jointly, produced in the teaching hospital.

The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs -- education is not simply a by-product. Adding the educational role involves additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. These costs are real. If graduate medical education is to continue, these costs cannot be avoided. Therefore, the growing debate about financing graduate medical education should

*Graduate Medical Education: Proposals for the Eighties (1981) and Physicians for the Twenty-First Century (1984).

not be one about paying or not paying these costs. Rather, the debate should be about the most appropriate method of paying for the costs of residency training.

For the past several decades, the teaching hospital's added costs for residency training have been financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984 survey of stipends paid to housestaff show 81% of the stipends and benefits are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes patient service revenue has been and continues to be the primary source for supporting the total costs of graduate medical education.

The AAMC has had a long-standing policy on financing graduate medical education which was reaffirmed in 1980 when the AAMC published the report of its Task Force on Graduate Medical Education. This three-year task force recommended that:

Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospital (p. 94, emphasis added).

The recommendation was consistent with private payer practices and with Congressional intent for the Medicare program. Many Blue Cross agreements throughout the country explicitly provide for payment of these costs. Congress clearly established payments for residents in training as a legitimate Part A Medicare expense in the original Medicare statute.

The AAMC continues to believe patient charges and reimbursements are an appropriate method of financing graduate medical education. In fact, if all, or most, of the nation's hospitals participated in graduate medical education, patient service financing of residency training could survive in the face of the increasingly competitive hospital marketplace. However, only 2 percent (125) of the nation's 5,900 community general hospitals provide 50 percent of the nation's residency training. Another 1,100 hospitals provide the remaining half of residency training. These 1,225 hospitals bear the cost of training the nation's entire supply of residents. The remaining 4,600 community hospitals -- as well as health maintenance organizations, competitive medical plans, and preferred provider organizations -- obtain the benefits of fully trained physicians without sharing in the cost of the training itself. This gives the non-teaching hospital an advantage in setting its charges and negotiating contracts. In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded.

The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and explore future alternatives for financing residency training. The Committee is chaired by J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and the members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the Committee were held in November, January and February and alternatives for financing graduate medical

education were explored. This paper has been prepared to summarize the discussions of the Committee and to explain the competing views on the issues of financing graduate medical education reviewed by the Committee.

The Committee's discussions have focused on five topics:

- o the need for special funding for graduate medical education in the patient care payment environment that is evolving;
- o the advisability of creating a societal funding mechanism for graduate medical education rather than having each payer establish its own policies;
- o the number of training years to be financed with any separate funding and the resulting manpower controls that accompany various alternatives;
- o the increasing use of non-hospital sites, especially ambulatory care settings, for residency training; and
- o the responsibility for training physicians educated in foreign medical schools.

The remainder of this report explores each of these topics in some detail in order to provide AAMC members, physicians and hospitals, third party payers, and public policy analysts with an understanding of the conflicting viewpoints within the medical education community.

The Need for Separate Funding

Patient care financing of graduate medical education has well served teaching hospitals, physicians-in-training, and society for several decades. Hospitals have been able to expand positions available to meet the increasing number of medical school graduates, specialties have upgraded their basic clinical training requirements, new subspecialties in medicine and surgery have developed, and new technologies have been widely disseminated.

Some Committee members and some AAMC members believe that teaching hospitals may be able to compete in the new environment without separate funding for the higher costs that result from graduate medical education. Until evidence to the contrary is clear, they believe that it would be unwise for the AAMC to advocate alternate financing arrangements which may jeopardize some of the benefits of the current system. These benefits include the freedom of medical students to elect to train in the specialty of their choice and the ability of teaching hospitals to offer a variety of residency programs.

The competing view, held by the majority of the Committee and many AAMC members, is that patient revenues in the future price-competitive market may be insufficient to support financing of graduate medical education and that alternatives must be found or at least explored. This group believes payers will withdraw their explicit support and/or cut back on their implicit support for graduate medical education. As a result, teaching hospitals will be forced either to limit other hospital programs and services to support the educational mission or to reduce the numbers of residents and faculty they support. Other missions also may increasingly draw on the resources of the teaching hospitals. For example, many teaching hospitals are being asked to provide increasing amounts of care to the indigent without concomitant increases in state or local

support. Thus, institutional resources are being stretched substantially and may be unable to support educational programs at current levels.

In substantial part, this dichotomy of viewpoints reflects different member experiences and points of reference. Those who advocate continuing to finance graduate medical education with patient service revenues present their viewpoint with reference to a payment system based on negotiated prices. They believe the teaching hospital has a marketable resource in its educational activities. They see education providing a quality-enhancing benefit not available from non-teaching hospitals. Moreover, in a negotiated market, a hospital is free to reject a price which does not enable it to meet its patient care and educational costs.

Those who advocate establishing separate financing for graduate medical education present their view with reference to a payment system based either on administered prices set by an external entity or on a payment system dominated simply by lowest price. For example, Medicare's basic prospective payment formulas are designed to pay a fixed price for a given patient irrespective of whether the hospital does or does not offer residency training. Unless separate funding is added, such as Medicare's current medical education passthrough, the teaching hospital must provide two products (i.e., patient care and education) for the same price the non-teaching hospital must provide only patient care. For non-Medicare payers, if price is the only selection criteria, there will not be additional funding for graduate medical education.

Given these differing reference points and perspectives, the AAMC faces two fundamental but conflicting assumptions:

public and private payers will recognize the unique contributions and benefits of teaching hospitals and be willing to pay teaching hospitals higher payments. As a result, the AAMC need not explore alternative arrangements for financing graduate medical education;

or

public and private payers of hospital services are becoming increasingly resistant to including adequate funding for the support of graduate medical education in their general patient care payments. As a result, the AAMC must explore options to provide support for this essential mission of teaching hospitals.

Resolution of this fundamental difference in working assumptions must precede discussions about the methodologies and structures for financing graduate medical education.

The Committee premised its development of alternative financing arrangements on the latter assumption cited above. This does not imply that it is inappropriate to finance GME with the general operating revenues of teaching hospitals. It does recognize, however, that in the future new payment systems for patient services may not provide teaching hospitals with sufficient funds to finance both their patient care and educational missions. Therefore, the Committee has explored alternatives and identified conflicting issues that must be resolved.

Scope of Proposals

Health care financing arrangements, both public and private, are undergoing substantial changes:

- o payers are increasingly interested in paying only for the immediate services used by their beneficiaries,
- o predetermined payments are replacing retrospective cost reimbursement, and
- o low price is replacing access as a criteria for selecting hospitals.

In this environment, each payer has an economic advantage in behaving as a marginal price purchaser paying only the incremental costs arising from services provided to its patients. This behavioral incentive, however, is in conflict with the broader societal interest in maintaining and supporting commonweal services benefiting all collectively but no payer individually.

Adequate financing for graduate medical education requires each payer to subordinate some of its economic self-interest to the broader social interest of adequately training new physicians. This subordination of self interest can be achieved in two ways: (1) society can impose a tax to support the costs of residency training or (2) payers can individually be persuaded for social, ethical, or public image reasons to share in financing residency training.

The Committee recognizes advantages and disadvantages to each approach. The taxation approach is the most likely to provide comprehensive financing and to avoid conflicting health manpower policies across payers. However, requiring a Federal tax, administered by Federal officials, seems to be contradictory to the present political climate. Moreover, it would make residency training dependent on a single source of funds and subject it to annual debates in the Federal budget. Such fiscal control could lead to massive intervention in medical education. Similar reservations exist for state-administered taxes. In addition, a state tax approach could lead to conflicting manpower policies across the nation.

The individual payer approach does not require major Federal legislation or a new bureaucracy and it permits manpower training decisions to remain at the institutional level. It is not clear, however, whether payers will subordinate their economic self interest. Some may; others may not. As a result, the revenue base for residency training may be incomplete and constantly changing.

The preferred course is unclear. Should the AAMC seek a comprehensive, national tax or should the AAMC concentrate on national payers (e.g., Medicare) while individual members work with their state and with individual payers? Each choice has major risks.

The Training Period To Be Funded

If separate funding is provided to support graduate medical education, the amount of that funding could be set by determining the number of residents to be financed and the number of training years to be supported. Three options on the length of training which would be supported by separate funding are available: (1) fund residents for a fixed number of years (e.g., 3, 4, or 5) regardless of the specialty in which the resident is training; (2) fund residents only for the period of time necessary to obtain initial board eligibility; or (3) fund residents in all accredited programs for initial and subspecialty training.

Option one provides separate funding for a fixed number of years per resident. Residents in programs which can be completed in the fixed number of years are supported throughout their training. Residents in the longer programs would receive funding for the fixed number of years but they, the hospital and the staff physicians would have to support the remaining years with patient service revenues, grants, appropriations, contracts, or philanthropy. For example, if the separate funding were provided for the first three years of residency training, residents in three year programs would be supported for all training years. Residents in programs lasting four or more years would receive separate funding only for the first three years of their program. Thus, under the three year example, residents in family practice, pediatrics, and internal medicine would receive funding throughout their basic training. Residents in all other specialties and subspecialties would receive funding only for the first three years of their program. Advocates of fixed year funding emphasize two

advantages to the approach. First, it minimizes external regulation. It does not require an external entity to allocate residency positions by specialty or across hospitals because payment is made based solely on the number of residents at or below the fixed years of training. Secondly, the advocates generally believe it will increase the proportion of residents training in the primary care specialties and decrease the proportion of residents undertaking subspecialty training. Detractors are concerned that the fixed year funding creates instability and uncertainty for residency programs lasting beyond the fixed year threshold. They note that strong training programs are built across time and need stability of financing and personnel. Detractors are also concerned that funding less than the years required for certification may lead to: inappropriate efforts to shorten training time, residents who drop out of training programs before completing them, or fee-for-service billing for residents who have not completed their training programs.

A second alternative varies the number of years of separate funding with the number of years of specialty training required for initial board certification. Residents in internal medicine would be supported for the three years of internal medicine with no separate funding provided for subspecialty training. Residents in surgery would be supported for the five years required for general surgery with no additional separate funding provided for the extra years required for thoracic, plastic, or colon and rectal surgery. The principal advantage of this alternative is its explicit recognition of the variation in the time required for initial board certification in different specialties. Some Committee members are concerned that separate funding which varies with the training required for initial board eligibility may lead to the development of a manpower planning entity which designates the number of approved positions in each specialty. The majority of the Committee believes, however, that a manpower planning entity is not necessary if separate funding is limited to the initial training program.

The majority also believes their position would be strengthened if the number of years of support for each specialty is limited to the present requirement. The major disadvantage of this alternative is its limitation to initial board eligibility. In many specialties -- including internal medicine, pediatrics, and surgery -- some residents undertake subspecialty training after they have completed, or could have completed, the initial residency. This alternative would not provide separate funding for residents in subspecialty training. Other sources of financing would be needed to support subspecialty programs.

The third alternative provides separate funding for all residents training in approved training programs. This approach provides separate funding for full specialty and subspecialty training in all disciplines. Advocates of this approach emphasize that it provides full funding for the period of time that the physician-in-training is subject to the direction and supervision of faculty. It does not provide an economic disincentive to developing or pursuing the longer training programs. Detractors note the open-endedness of this approach. They believe the funding entity is likely to limit its financial exposure under this option by developing explicit manpower training policies. The detractors are concerned that some entity may determine how many positions in each type of training will be offered and which hospitals will be approved for funding.

The three funding options are dramatically different. They vary in terms of ease of administration, financial comprehensiveness, and likely manpower regulation. Each approach has supporters. Selection of any one approach will bring fundamental change to residency training.

Non-Hospital Training Sites

Increasingly, acute care hospitals are being used only for the most intensive portion of a patient's illness or procedure. This has changed both the kinds of cases admitted to inpatient units and shortened the length of time the patient is in the hospital. As a result, several specialties are now trying to incorporate non-hospital experiences in their residency programs. This creates problems because hospital patient care revenue has been the predominate source of support for residency training. While hospital charges and costs presently include expenses for graduate medical education programs, ambulatory care providers do not have such costs in their present charges. Increasing charges in ambulatory or long-term care settings to support residency training would disadvantage some providers as price competition in all areas of medical care increases. Innovative financing approaches must be developed and evaluated for both long-term care and ambulatory settings.

Residency Positions To Be Supported

The United States has 127 medical schools accredited by the Liaison Committee on Medical Education (LCME) and 15 accredited osteopathic schools from which there are a total of approximately 16,200 graduates. The AAMC Committee believes that the United States has an obligation to provide the resources necessary to train these graduates. The Committee believes society has no similar obligation to provide and financially underwrite graduate medical education for graduates of non-accredited medical schools or schools outside the U.S. At the present time 18% of residency training positions are occupied by physicians graduating from foreign medical schools. While some U.S. hospitals may wish to continue training foreign graduates, the Committee believes such training need not be supported by funding arrangements designed to support graduate medical education. Because almost twenty percent of current residents

are foreign medical graduates, adoption by payers of the Committee's position would substantially reduce the funding needed for graduate medical education.

Conclusion

This statement of issues is focused on five major topics surrounding the future financing of graduate medical education. The Committee recognizes that numerous secondary issues have not been addressed. For example, approaches which increase the uncertainty of residency support may discourage economically-disadvantaged individuals from choosing a medical career. Eliminating funding for foreign medical graduates may pose special transition problems for patient services in some hospitals. The Committee is aware of these and other secondary concerns but chose to omit them in order to address the primary topics in a more tightly focused way.

During the last two decades, hospitals have operated for the most part in a cost reimbursement era with substantial autonomy. They have competed with each other on the basis of quality and scope of services; there was minimal competition on the basis of price. The Committee recognizes that the environment of the mid-80's and beyond is different and that hospitals must improve the efficiency of all their services. Price per unit of service is becoming the basis of competition. Even efficient teaching hospitals are disadvantaged in the price competitive market for a variety of reasons including:

- o the provision of a disproportionately large share of care to the indigent;
- o the treatment of the most severely ill patients;

- o the provision of regional stand-by services, such as burn centers, pediatric and adult open-heart surgery centers, and transplant centers;
- o the presence of clinical research efforts to advance diagnostic and treatment capabilities; and
- o the provision of graduate medical education to maintain the supply of physicians for this country.

All of these functions are important to the missions of teaching hospitals, and all make teaching hospitals more expensive to operate than non-teaching hospitals. The Committee's task is to examine only changes in the financing of graduate medical education, but it clearly recognizes that even if separate funding for graduate medical education is adopted, teaching hospitals will continue to require special consideration in any hospital financing scheme for the other functions that distinguish them from non-teaching hospitals. While financial support for graduate medical education will not eliminate the teaching hospital's problems, support for GME will contribute to a more equitable market in which teaching hospitals are less disadvantaged.

SUMMARY OF RESPONSES
TO FINANCING GRADUATE MEDICAL EDUCATION QUESTIONNAIRE

ATTACHMENT B

<u>Questions and Responses*</u>	<u>CAS</u>	<u>COD</u>	<u>COTH</u>
<u>Question 1.</u>			
Can your hospital compete on a price basis and maintain current levels of graduate medical education?			
a. Yes	2	13	27
b. No	29	54	71
Yes, but would cut back on specialists	1		
Not Applicable/No Answer		2	2
Unknown		1	2
Some Yes, Some No		1	
<u>Question 2.</u>			
Should AAMC take a clear position opposing Medicare funding of FMGs?			
a. Yes, oppose funding for both U.S. and alien FMGs	22	50	61
b. Yes, but only oppose funding alien FMGs	3	10	25
c. No, take no position	4	10	13
Deal with manpower issues separately	3		
AAMC should set criteria for "approved" residency		1	
Oppose funding U.S. FMGs only			1
Oppose funding FMGs, but couple with policy for care of indigent			1
<u>Question 3.</u>			
If there is separate funding for graduate medical education, which option should the AAMC support?			
a. funding for a fixed number of years	6	15	6
b. funding to initial board eligibility with possible manpower constraints	16	48	80
c. fund to completion of training with real manpower constraints	10	6	14
Fund 1st year and allow billing fee-for-service afterward (ala I.G.'s) draft report.		1	
No answer		1	3

*Set responses were offered on the questionnaire, but some respondents chose to write-in their answers. These write-in responses have been included in this summary and are distinguishable because they do not have a letter preceding them.

Financing Graduate Medical Education
Questionnaire for AAMC Members

The issues involved in the current debate over the financing of graduate medical education are complex. The Statement of Issues paper attempts to describe some of the competing views regarding possible policy recommendations the AAMC could pursue. In order to be sure we have given careful consideration to our members' concerns we ask you to respond to this questionnaire. The result will be shared with Dr. Buchanan's Committee on Financing Graduate Medical Education. Please feel free to augment your comments here by either attaching additional pages or by writing to Dr. Buchanan.

1. Teaching hospitals are facing an increasingly price sensitive market. Can your hospital compete on a price basis with non-teaching hospitals and continue to support graduate medical programs at current levels?

_____ Yes

_____ No

2. Currently 18 percent of the residents in this country are foreign medical graduates. Approximately half of the FMGs are U.S. citizens and the other half are aliens. Should the AAMC take a clear position opposing Medicare funding of residents who are foreign medical graduates?

_____ Yes, oppose funding of both alien and U.S. FMGs

_____ No, oppose funding alien FMGs only

_____ No, AAMC should take no position

OVER

3. Which of the three options do you believe the AAMC should favor if there is to be separate funding of graduate medical education?

- _____ (1) fund residents for a fixed number of years (e.g., 3) regardless of the length of their training and impose no explicit manpower constraints,
- _____ (2) fund residents for the training necessary to attain initial board eligibility and possibly have some manpower constraints imposed on the number of residency slots to be funded in each specialty, or
- _____ (3) fund residents in all accredited programs for initial and subspecialty training and accept the manpower planning constraints which will be imposed.

Name (optional) _____ Discipline _____
Institution _____ Date _____

SUMMARY OF TESTIMONY OF THE
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES: RECOMMENDATIONS
ON MEDICARE FINANCING
OF GRADUATE MEDICAL EDUCATION

The Dole-Durenberger-Bentsen Proposal (S.1158)

- A. Hospitals face the inflation present in the national economy as a whole. Therefore, the AAMC recommends

THAT S.1158 BE AMENDED TO PROVIDE THAT THE MEDICARE PASSTHROUGH FOR MEDICAL EDUCATION COSTS BE INCREASED BY THE SAME PERCENTAGE USED TO INCREASE THE FEDERAL COMPONENT OF THE DRG PRICES.

- B. In recognition of the fact that the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes

SUPPORT THROUGH INITIAL BOARD ELIGIBILITY IS AN ESSENTIAL MINIMUM TRAINING PERIOD THAT EVERY PATIENT SERVICE PAYER SHOULD HELP FINANCE.

- C. If Part A payment is to be limited to the initial eligibility required to produce a competent practitioner, the AAMC recommends

AMENDING S.1158 TO ALLOW PART B BILLS TO BE RENDERED FOR PHYSICIAN SERVICES PROVIDED BY INDIVIDUALS IN RESIDENCY YEARS WHICH MAY NOT BE INCLUDED IN A HOSPITAL'S COSTS.

- E. The AAMC believes society has a responsibility to provide necessary clinical training for physicians from U.S. schools, and recommends

AMENDING SECTION (P)(iii) TO ELIMINATE MEDICARE SUPPORT FOR ALL RESIDENTS WHO ARE NOT GRADUATES OF ACCREDITED MEDICAL (OR OSTEOPATHIC) SCHOOLS LOCATED IN THE U.S. OR CANADA.

- F. Because abrupt elimination of foreign medical graduates would cause substantial access and service problems for Medicare beneficiaries, the AAMC recommends

THAT S.1158 BE AMENDED TO PROVIDE A THREE YEAR PHASE-OUT FOR MEDICARE SUPPORT OF RESIDENTS GRADUATING FROM FOREIGN MEDICAL SCHOOLS.

Section (P)(ii): Initial Board Eligibility

Education for the contemporary practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Because medicine involves a number of different specialties, each specialty area has developed its own residency training period. The AAMC believes each of those training programs is essential and in the national interest; however, in the present fiscal situation, the AAMC understands program policies and fiscal policies must be balanced. The AAMC believes that any limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. S. 1158 would limit funding in each specialty field to the minimum number of years required for initial board eligibility. Because the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes

support through initial board eligibility is an essential minimum training period that every patient service payer should help finance.

It should be understood that this approach does not provide full support for the subspecialty fields of internal medicine, some surgical subspecialties, and a few other subspecialties. In his statement accompanying the introduction of S. 1158, Senator Bentsen observed

. . . I am not yet satisfied that the question of funding graduate fellowships has been properly addressed, particularly as it relates to internal medicine residencies." (Congressional Record, S6344).

The AAMC shares the Senator's concerns. The AAMC does not want to leave the impression that these programs are either unnecessary or conducted without training costs. Therefore, the AAMC requests that any legislation limiting Medicare's financing role to initial board eligibility include in its accompanying Committee report a clear statement that it is an appropriate function for other Federal agencies and programs -- such as the Public Health Service, the Veterans Administration, and the Department of Defense, as well as other public and private sources -- to support subspecialty training beyond primary board eligibility. Moreover, the AAMC suggests that Section (P)(i)(II) be modified to require the Secretary to examine fellowship training in addition to the number of years of training required for initial board certification.

From: AAMC testimony before Senate Finance Committee, June 3, 1985

FEDERAL POLICY ON GRADUATE MEDICAL EDUCATION --
CURRENT INITIATIVES

As of the beginning of October, the individual House and Senate authorizing committees responsible for budget reconciliation legislation related to Medicare and Medicaid had completed their work. Several of the changes proposed by this legislation, which is necessitated by the spending ceilings imposed by the budget resolution, would have significant effects on both the Medicare direct medical education passthrough which reimburses Medicare's share of residency costs, and the indirect medical education adjustment which adjusts DRG prices to compensate increased severity of care in teaching situations.

Direct GME Payments

House

In the House, the Committee on Ways and Means, which is responsible for Part A of Medicare, and the Committee on Energy and Commerce, which is responsible for Medicare Part B and Medicaid, voted to combine their respective bills into one piece of legislation, H.R. 3290. This bill contains three specific provisions that relate to the funding of graduate medical education. First, the bill would make no change in the current calculation of the Medicare direct graduate medical education passthrough for fiscal 1986. The Committee on Ways and Means voted to prohibit the administration from implementing a freeze on the direct medical payments to teaching hospitals for housestaff training. Thus teaching hospitals would continue to be paid the Medicare portion of their actual expenditures for residents' stipends and benefits, faculty costs, and related and allocated overhead costs.

H.R. 3290 also includes a proposal, approved by the Committee on Energy and Commerce, to alter the Medicaid payments for graduate medical education. This proposal is a modified version of what Representative Waxman (D-CA) proposed in H.R. 2699. The plan calls for each teaching hospital to calculate its average cost-per-resident (including stipends and benefits, faculty costs, and related and allocated overhead) from its most recent cost report. No hospital's allowable costs could exceed 175 percent of the national average cost-per-resident in the first year of the plan, 150 percent in the second year, and 125 percent thereafter. The allowable cost-per-resident would be adjusted by the annual change in the Consumer Price Index (CPI). To determine how much the hospital would receive, the adjusted allowable cost would then be multiplied by a count of residents, which is weighted to favor "primary care" residents. At full implementation, these weighting factors would count each primary care resident as 1.3, each non-primary care resident who has not yet reached initial board eligibility or five years as .7, and each resident beyond initial board eligibility or five years as .5. Primary care residents are defined as individuals during the first three years of training for internal medicine, pediatrics, or family medicine who have not been accepted for subspecialty training, and individuals in the first two years of

geriatrics, public health, or preventive medicine programs. Foreign medical graduates (FMGs) could be counted only if they pass the FMGEMS.

Senate

In the Senate, two separate proposals exist. The first, which was approved by the Committee on Finance, is a modification of the Dole-Durenberger bill (S.1158) on the direct graduate medical payments. In its initial year of implementation (fiscal 1985) this bill would freeze the Medicare and Medicaid direct graduate medical education passthrough at the fiscal 1984 level. In the succeeding years, teaching hospitals would receive the costs incurred for residents' training until they reach board eligibility or five years, whichever is less. Medicare and Medicaid support for graduate medical education would be limited to graduates of LCME-accredited medical and osteopathic schools. Support for FMGs would be phased out over a three-year period (five years for institutions with more than 50 percent FMGs).

The second Senate proposal that may effect graduate medical education funding is S.1210, which was introduced by Senators Quayle and Hatch, and approved by the Committee on Labor and Human Resources. This committee does not have jurisdiction over Medicare and Medicaid, but it does have authority over health manpower issues. S.1210 would establish a national graduate medical education advisory committee, which would recommend minimum percentages of primary care residency positions to the Secretary of Health and Human Services. Hospitals would be permitted to join a registry of institutions in compliance with these "voluntary" minimums by submitting an assurance to the Secretary that they would follow -- either individually or as part of a group -- these targets.

The committee has already moved toward mandatory compliance, however, by agreeing to a Kennedy proposal to amend this bill on the floor of the Senate to link compliance with Medicare and Medicaid funding. The Kennedy amendment would provide bonus payments for hospitals that achieve, or make progress toward achieving the manpower targets. As this proposal is budget neutral, it implies that those institutions that did not achieve the recommended minimum percentages would be penalized. In addition, hospitals would be precluded from having FMGs as more than 25 percent of the total residents or as more than 25 percent of the residents in any program with 8 or more residents.

Indirect Adjustment

House

H.R. 3290 also would reduce the indirect medical education adjustment from the current 11.59 percent for every 0.1 resident-per-bed to 8.1 percent for the first 0.1 resident-per-bed. This adjustment was motivated by two factors. First, the regression analysis used to calculate this adjustment was recomputed using more appropriate variables and found to be 8.7 percent for the first 0.1 resident-per-bed and somewhat less for each additional 0.1 resident-per-bed. Second, the Committee on Ways and Means also provided an additional adjustment for hospitals caring for a disproportionate percentage of low income and Medicare patients. This "disproportionate share adjustment" is intended to account in part for the greater Medicare costs reported by hospitals serving low income patients. To date, the Medicare Prospective Payment System has inadequately accounted for these costs, which result from

treating low income and elderly patients who commonly have multiple complications, in its DRG payments. The indirect "education" adjustment, in fact, has served as a proxy for severity of treatment in these institutions. The disproportionate share adjustment is based on the ratio of Medicaid and Medicaid "eligible" Medicare patient days to total patient days.

Senate

The portion of the Finance Committee proposal that deals with the indirect medical education adjustment (S.1606) would also reduce the indirect medical education adjustment from 11.59 percent to 7.7 percent for the first 0.1 resident-per-bed and somewhat less for each succeeding 0.1. This proposal includes a disproportionate share adjustment which differs from the House proposal in being calculated on the proportion of Medicare patients eligible for both Medicare and Medicaid.

JOINT AAMC-AAU AD HOC COMMITTEE
ON THE GOVERNANCE AND MANAGEMENT OF INSTITUTIONAL ANIMAL RESOURCES

Within the last several years a number of our institutions have carefully scrutinized the governance and management of their animal resources. These efforts have produced some valuable insights into ways to improve these procedures and to insure a high institutional priority for efforts to maintain the highest standards for humane care and use of animals in research and education. The Executive Councils of the AAMC and the Association of American Universities (AAU) determined that it would be a worthwhile endeavor to form a joint Committee which would review and summarize this experience in a series of generic recommendations for institutions concerning the governance and management of institutional animal resources. The resulting document could then be made available to assist all universities with research or education programs involving animals in their efforts to provide an optimal setting for these programs. The Committee met in early July 1985 and thoroughly debated a draft document based on advice and comments from a wide array of institutions.

The attached report prepared by the Committee presents a series of recommendations addressed to those responsible for all components of an institution's programs which use animals in research and education. This document was endorsed by the AAMC Executive Council in September and has been submitted to the AAU governance for ratification on October 22. A copy of the document as approved by AAMC is attached. We anticipate that this document will be circulated widely within our universities, teaching hospitals, and medical schools and hope that it will assist collaborative efforts within our institutions to coordinate and improve collective institutional as well as individual responsibility for the humane care and use of animals.

MEMBERS OF THE JOINT AAMC-AAU AD HOC COMMITTEE
ON THE GOVERNANCE AND MANAGEMENT OF INSTITUTIONAL ANIMAL RESOURCES

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RECOMMENDATIONS FOR GOVERNANCE AND MANAGEMENT OF
INSTITUTIONAL ANIMAL RESOURCES

Preamble

During the last quarter century, the momentum of discovery in the biological, behavioral and medical sciences has steadily increased, while the application of this new knowledge has brought incalculable health benefits to mankind. Laboratory animals have played an indispensable role in these advances and in the education of professionals who serve the medical and health needs of humans and animals.

If the public's rising expectations for relief from disease, disability, and premature death are to be realized, research involving laboratory animals must continue. Thus, significant responsibility for the governance and management of laboratory animal resources devolves upon individual investigators and faculty, as well as the institutions in which their research and instruction is performed. All individuals whose work requires them to use animals in education or scientific inquiry must understand and be committed to fulfilling the legal and moral responsibilities of such use for both ethical and

An ad hoc Committee for the Governance and Management of Institutional Animal Resources was established at the direction of the Association of American Medical Colleges and the Association of American Universities and was charged to review systematically university policies and procedures regarding the governance and management of animal resources and to recommend general guidelines that would support good practices in the management of institutional animal resources.

scientific reasons. Only healthy, well-cared for animals yield valid scientific data, and thus both practical and philosophical considerations enjoin us to the highest standards of care.

The academic community has a responsibility for meeting two challenges. First, it must assure that all animal facilities, as well as research and training procedures, are beyond reproach and are in compliance with all applicable laws, regulations and guidelines. Though deficiencies in compliance with these standards may be rare, those that do occur only serve to undermine public confidence in all research and must be corrected. Where fiscal constraints have limited the development of state-of-the-art facilities, efforts to obtain the necessary resources should be redoubled. Second, the academic and scientific community must educate the non-scientific public about the important benefits to be derived from the use of animals in research and education.

This document has been prepared to assist universities and medical schools in their efforts to support research and instruction involving animals by making recommendations for improving coordination and communication among the many units of the university involved in animal use. It does not prescribe specific technical procedures or guidelines for the treatment of animals; rather, it is intended to augment the Animal Welfare Act, the NIH Guide for the Care and Use of Laboratory Animals, the PHS Policy on the Humane Care and Use of Laboratory Animals by Awardee Institutions, the U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training, the standards of the American Association of Accreditation of Laboratory Animal Care, and the many existing institutional policies.

The recommendations set forth below are addressed to those individuals -- administrators, animal resource managers, investigators, faculty, and public affairs officials -- whose wholehearted support is needed to maintain research and education in the current open environment. Their adoption may be of assistance in avoiding deficiencies in research protocols and instructional practices involving animals and may help to promote awareness among all segments of the university of the importance of animals to the success of the scientific and education missions. These recommendations should not be construed as organizationally prescriptive, but should serve as guidelines, recognizing that institutions are organized differently and may meet obligations in different ways.

Responsibilities of Institutional Chief Executive Officers

In order to develop and maintain a viable animal resource program at any institution, a strong commitment to the humane care and use of animals must be a high priority within its administration. Therefore, the following recommendations are directed specifically to institution presidents and deans, especially of medical, veterinary, and dental schools.

1. Establish firm, centralized administrative and financial support for animal use in research and instruction, and ensure that high standards for animal care are an institutional priority.
2. Designate one high-ranking "institutional official", reporting directly to the chief executive officer, to be responsible for the entire animal resource program and to coordinate with the administration, investigators, faculty, veterinarians and animal care committees to ensure a clear, visible chain of authority for the program.

In some of the larger decentralized universities, it may be desirable to have more than one "institutional official."

3. Move as rapidly as possible to meet the standards required for accreditation by the American Association for the Accreditation of Laboratory Animal Care (AAALAC) at each of the institution's animal facilities.
4. Encourage open communication and be receptive to needs for resources, facilities improvement, and better security measures.
5. Establish a university-wide public education campaign to educate the public and its political representatives regarding the need for animals in research and instruction and the important benefits that accrue from such use.
6. Establish procedures for and assume direct institutional leadership of any crisis situation that may arise. An assault upon animal use threatens the integrity and reputation of the entire university.
7. Be prepared to prosecute to the full extent of the law any individual(s) involved in crimes against the institution such as laboratory break-ins and theft or destruction of property.

Responsibilities of the Institutional Official

The primary role of the institutional official is to administer the animal program and to promote open communication with each functioning unit of the institution (e.g., medical school, veterinary school, psychology department) involved in animal care and use. The following recommendations are offered to facilitate those responsibilities.

1. Ensure that all animal facilities are in compliance with applicable requirements of the Animal Welfare Act and pertinent state and local laws and regulations, and adhere to the PHS Policy, the NIH Guide, and the U.S. Interagency Research Animal Committee Principles.
2. Coordinate the university's public education campaign regarding the benefits of animal use, seeking input from investigators, faculty, veterinarians and students.
3. Establish or modify animal care committees to meet the standards specified in the PHS Policy on the Humane Care and Use of Laboratory Animals. Expect these committees to insist upon the highest quality animal care and facilities, and to support and promote research in compliance with existing standards.
4. Ensure that the use of animals in education is reviewed to make certain that all regulations and guidelines are being followed.
5. Require good recordkeeping practices for all aspects of the animal program, particularly APHIS inspection reports and records of all actions taken to correct deficiencies, AAALAC reports, animal welfare assurances, and animal care committee reports, activities and recommendations.
6. Systematically review the status and condition of each functioning research unit. Each unit should be required to prepare a periodic assessment of its animal program, fully describing any problems or deficiencies and the schedule for corrective action, the resource needs of the facility (i.e. repairs, renovation, new construction), and its accreditation status.

7. Develop and implement when necessary an institutional plan for dealing with an attack on animal facilities or an assault on the merit or validity of specific research projects. Involve the university administration, veterinarians, principal investigators, animal care committee(s), public affairs officials and the general counsel.

Responsibilities of the Animal Resource Director

The following recommendations are provided for animal resource directors or veterinarians-in-charge, who are in a unique position to ensure the smooth functioning of the animal care program on a daily basis.

1. Provide a comprehensive program of veterinary medical care for all animal colonies, employing properly trained veterinarians, technicians and caretakers. Diagnostic resources, preventive medicine, post-surgical care and mechanisms for emergency care are important components of a sound animal program.
2. Develop institutional guidelines which incorporate the applicable requirements of the Animal Welfare Act, NIH Guide, PHS Policy, IRAC Principles, and AAALAC standards, taking into consideration the occasional inconsistencies in those requirements.
3. Provide full support for each approved research protocol, assisting the investigators in achieving the highest standards of animal care in the particular context of their research.
4. Ensure that animal care personnel are aware of the high institutional priority of keeping all animal facilities (including off-campus sites) in compliance with the standards of the Animal Welfare Act, the NIH Guide, or where applicable, the requirements of AAALAC.

Develop a comprehensive plan to serve the sanitation, housekeeping and maintenance needs of each research and teaching unit.

5. Prepare and distribute manuals and guides which summarize the institutional policies and procedures regarding procurement, housing, care and use of laboratory animals to all individuals/departments that are involved in animal research or instruction.
6. Ensure that hiring policies promote the selection of employees who are professionally dedicated to the appropriate care and use of animals.
7. Establish and promote continuing education and training in animal care for those individuals involved in the use of animals in research or classroom instruction.

Responsibilities of Investigators

Since the support of investigators is crucial to maintaining high standards of animal care in any research setting, the following recommendations are provided for implementation by research faculty and staff.

1. Become knowledgeable about and conduct all research and inquiry in accordance with approved policies governing the care and use of laboratory animals.
2. Submit research protocols, as required by animal care committees, accompanied by a short lay description of the project and its intended benefits for use as needed by the institution's animal care committee or public affairs representatives.

3. Maintain complete records of procedures undertaken during all animal experiments.
4. Meet research protocol requirements in approved, centralized facilities whenever possible. Where research protocols dictate unusual environmental, dietary or colony requirements that cannot be met in central facilities, be sure the research team and caretakers appreciate the need for these special conditions.
5. Conduct a thorough orientation for students, postdoctoral fellows, technicians, animal care workers, and others participating in research on the rationale for the use of animals in each protocol. Be sensitive to the needs of newcomers to adjust to participating in research performed on animals.
6. Maintain a scholarly, sensitive, respectful environment during all animal experimentation.
7. Participate in continuing education and training programs designed to keep investigators abreast of the latest techniques and procedures in animal research.
8. Devote time and effort to university-wide activities to promote a general understanding within the university community and the lay public of the need for animals in research and instruction.
9. Emphasize the role of laboratory animals when presenting research results or discussing human diseases with lay audiences and describe the contributions of humanely conducted animal studies to the development of new technologies and treatment capabilities.

Responsibilities of Faculty Using Animals for Instructional Purposes

Although there has been a dramatic reduction in the use of animals for instructional purposes over the past two decades, live animals remain an important and necessary adjunct teaching model in certain courses. The following recommendations are therefore directed to faculty members involved in this type of instruction.

1. Ensure that animals used for instructional purposes in classrooms or laboratories receive the same humane care and treatment as those used for research purposes.
2. Review any teaching methods involving animals to ensure that all regulations and guidelines are being followed.
3. Promote sensitivity and concern among students for the need for humane care and treatment of animals.

Responsibilities of Institutional Animal Care and Use Committees

Institutional Animal Care and Use Committees (IACUCs), in addition to their prescribed duties, act in an advisory capacity to the institutional official and serve as a valuable resource in the conduct of research and instruction at institutions. In order to further enhance the role of these committees, the following recommendations are offered.

1. Evaluate existing institutional policies, standards, procedures, guidelines and manuals relating to laboratory animal care and use and conduct reviews regarding the adequacy of animal facilities. Make recommendations for any appropriate modifications to the institutional official.

2. Maintain and promote an open and cooperative relationship with investigators, faculty, the animal resource director and the the institutional official.
3. Support scientific justifications for research protocols that necessitate a departure from conventional care and use requirements, and document ~~all discussions regarding~~ the committee's rationale for its approval of such departures.
4. Keep careful records and ensure the confidentiality of all committee proceedings and activities, including any information that relates to trade secrets, research protocols and procedures, and other privileged data.

Responsibilities of University Public and Government Affairs Officials

Public and government affairs officials are often called upon by the media and the public to respond to inquiries about research being conducted at their institutions, and may be the first persons contacted in the event of a demonstration or criminal act directed at the institution. The following recommendations are therefore directed toward these officials.

1. Become familiar with the types and objectives of the research being conducted at your institution.
2. Identify and train several articulate, effective speakers from the research and teaching faculty who could be called upon to explain to the public the need for and benefits of using animals in research projects and instruction.

3. Participate in the university-wide public education campaign to educate the lay public, the media, and political and governmental officials regarding the importance of animals to research and teaching at your institution.
4. Nurture community relations by scheduling speakers to elaborate on the necessity of animal research to civic and lay groups.
5. In your contacts with federal, state and local officials and their staffs, keep them informed of the importance of animal research.
6. Develop methods to keep institutional officials, investigators, veterinarians and lab personnel informed of the concerns and activities of animal rights organizations.
7. Ensure that, where applicable, the role of laboratory animals is emphasized appropriately in press releases on scientific discoveries at your institution.
8. As part of the crisis management plan, provide spokespersons to discuss the nature and objectives of research with the media. While it is helpful to respond immediately to allegations of animal abuse, it is equally important for an articulate expert to discuss objectively this research and the generic need for animals in research.

REFERENCES

Animal Welfare Act of 1966 (Public Law 89-544), as amended by the Animal Welfare Act of 1970 (Public Law 91-579) and by the 1976 Amendments to the Animal Welfare Act (Public Law 94-279).

Regulatory authority under the Animal Welfare Act is vested in the Secretary of the U.S. Department of Agriculture (USDA) and implemented by the USDA's Animal and Plant Health Inspection Service (APHIS). Rules and regulations are codified in the Code of Federal Regulations (CFR), Title 9 (Animals and Animal Products), Subchapter A (Animal Welfare), Parts 1, 2, and 3. Copies can be obtained from the Deputy Administrator, USDA, APHIS-VS, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782

National Institutes of Health Guide for the Care and Use of Laboratory Animals, prepared by the Institute of Laboratory Animal Resources of the National Research Council for the National Institutes of Health of the U.S. Department of Health and Human Services. NIH Publication No. 85-23, revised, 1985. Copies may be requested from the Division of Research Resources, NIH, Building 31, Room 5B59, Bethesda, MD 20205.

Public Health Service Policy on Humane Care and Use of Laboratory Animals by Awardee Institutions, revised, June, 1985. Copies may be requested from the Division of Research Resources, NIH, Building 31, Room 5B59, Bethesda, MD 20205.

U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training, prepared by the Interagency Research Animal Committee for the Office of Science and Technology Policy. Adopted May, 1985. The Principles appear in the appendix of the PHS Policy on Humane Care and Use of Laboratory Animals by Awardee Institutions.

AAMC RESEARCH POLICY COMMITTEE

The ad hoc Committee on Research Policy of the Association was established in June 1985 at the request of the Council of Academic Societies to provide a focus for Association review and analysis of federal biomedical research policy. The Committee will respond to a series of initiatives by the NIH, the Executive Branch -- especially the OMB and the Office of Science and Technology Policy -- and various committees in Congress to examine, and in some cases alter, the present framework of policy for the conduct of biomedical research.

The ad hoc Committee has been charged to review and further develop Association positions on the federal role in biomedical and behavioral research in regard to these six contexts:

- goals of biomedical research
- research manpower and training
- the extramural award system
- support for institutional infrastructure
- funding for research
- formulation of biomedical research policy.

The Committee held its first meeting in August and plans further meetings in October and December.

The Committee anticipates formulation of its overall research policy positions sufficient to permit discussion with the constituent councils by Spring. The Committee also anticipates a role in facilitating an integrated Association participation in the public debate engendered by the recently constituted Science Policy Task Force of the House of Representatives as it conducts hearings and prepares a series of recommendations on federal research policy for public review in May 1986. The Science Policy Task Force, chaired by Representative Don Fuqua (D-FL), chairman of the present Science and Technology Committee of the House, is engaged in the first major congressional review of American Science Policy in nearly twenty years. The Task Force is conducting an in-depth examination of the major government policies for the conduct and support of basic and applied research across all the major scientific disciplines. It is examining the significant changes which have occurred in the science-government relationship and the overall environment for scientific research in the last twenty years, and attempting to identify and anticipate the proper role for government and the appropriate policies which should govern the federal investment in science in the coming decades.

A background paper delineating the key policy issues which will be addressed by the AAMC Research Policy Committee is attached, as is a list of the membership of the committee.

AAMC AD HOC RESEARCH POLICY COMMITTEE

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MEMBERS:

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BACKGROUND PAPER FOR RESEARCH POLICY COMMITTEE

Introduction

The unfortunate paradox that confronts this nation's biomedical and biobehavioral research enterprise is that at a time of scientific opportunities unparalleled in the struggle to seek knowledge and limit disease, the resources essential to pursue these opportunities are not keeping pace. As an example, in fiscal 1973, 3.8 percent (\$3.8 billion) of the \$99.4 billion expended nationally for health care went to research and development. By fiscal 1983, however, research and development accounted for only 3.0 percent (\$10.4 billion) of the \$350.8 billion in health care costs.

More specifically, obligations for the National Institutes of Health (NIH) in fiscal 1972 totalled \$1.506 billion. By fiscal 1982, NIH obligations in terms of 1972 constant dollars were \$1.696 billion -- an increase of only 1.3 percent per year in purchasing power over the decade. Only within the last three years, under concerted pressure from all sectors of the health research community, has the NIH budget again experienced real growth to \$2.145 billion in 1972 constant dollars by fiscal 1985. The ADAMHA budget for research and training exhibited virtually no growth in purchasing power between 1972-1984, going from \$149.5 million to \$152.4 million in constant 1972 dollars. FY 85 saw some improvement to an appropriation of \$163.5 million in constant dollars.

The recent gains, however, are threatened by congressional preoccupation with deficit reduction and the recent actions of the Office of Management and Budget (OMB), which has, in effect, impounded a portion of the fiscal 1985

appropriations for the NIH and ADAMHA. These are only the latest indications that the federal largesse for biomedical and biobehavioral research is limited. Faced with the likelihood of continued constraints on the federal resources available for biomedical science, the foremost questions in any discussion of research policy must be:

- How should these limited resources be invested?
- Who should be charged with the responsibility for these investment decisions?

Underlying these fundamental questions are a number of separate but related policy issues that also require resolution. The public debate has been clouded by efforts to expand the goals of biomedical research beyond the acquisition of knowledge and the improvement of health. The post-industrial evolution of the United States into a society based on knowledge, communications, and high technology has created a series of new expectations for science. Increasingly, biomedical research is charged with responsibility to protect not only the nation's public health, but since the emergence of the biotechnology industry, its economic health as well. Responsible policy discussions need to be based on an understanding of what can and should be expected from biomedical science.

There are policy issues related to each of the three roles that the federal government has traditionally assumed with regard to biomedical research -- its role in supporting research itself, and as a derivative, its roles in assuring the manpower supply and contributing to the research infrastructure. At various times the validity or appropriate extent of each of these roles has been questioned. Ten years ago there was considerable concern whether the support of research training was a legitimate responsibility of the federal government. More recently, the obligation of the federal government to

support the infrastructure at the research institutions has been discussed, most notably in the context of the administration's desire to limit payments for the "indirect costs" associated with NIH research grants, and the increasing clamor over the lack of federal investment to stem the deterioration of research facilities. At present, the NIH, OSTP, and the Congress are engaged in an examination of whether the government is actually investing in a system of research or simply purchasing research results with little responsibility for the milieu from which these scientific products are drawn. This debate about the extent of federal responsibility for infrastructure is critical because the growth of the biomedical research enterprise has long passed the point where the milieu can be sustained by the institutions without the assistance of the federal government.

The AAMC ad hoc Committee on Research Policy has been charged to review and further develop Association positions on the federal role in biomedical and biobehavioral research in regard to these six contexts:

- goals of biomedical research
- research manpower and training.
- the federal research award system.
- support for institutional infrastructure.
- funding for research.
- formulation of biomedical research policy.

In each of these areas a series of policy issues and questions are identified which may serve to guide the deliberations of the committee.

The Goals of the Federal Research Effort

Biomedical research in this country has traditionally been driven by two fundamental goals: the advancement of knowledge and the conquest of disease. The pursuit of these goals has resulted in the development of a research

establishment internationally recognized for its excellence that has contributed immeasurably to advances in health and the conquest of disease. The federal goal as embodied in the missions of NIH and ADAMHA is even more unitary; it is to use science to improve health. The AAMC has traditionally espoused the view that basic biomedical research itself should be a national goal as the foundation of applied science related to health, and that improvement in the health of the nation should be one of the primary concerns of government. The 1971 AAMC Committee stressed that world leadership and excellence in science itself were appropriate national goals and that, in the long term, improvements in the nation's health rested upon the willingness of the federal government to be the principal sponsor of biomedical research and to award a high priority to basic research.

Today the biomedical research enterprise is being increasingly subjected to pressures to achieve other objectives and meet other societal needs beyond improvement of health, as well as to pressures to adopt specific and limited goals and seek immediate solutions to a shifting array of public perceptions of the nation's health needs. Thus, there are two fundamental policy questions to be considered.

First, to what extent should the goals of biomedical research encompass broader societal concerns? Examples of such concerns are using scientific investment as a tool for regional economic development, assuming the burden of transforming society from an industrial base to a high technology base, maintaining the competitiveness of American industry in the world marketplace, supporting small businesses, assuring equity of access to career opportunities for underrepresented minorities, promoting geographic diversity of research centers, and enabling participation of all segments of the population in a society based on science and technology. Many of these legitimate societal

objectives have been at least partly achieved as an indirect result of a science policy directed toward the traditional goals of advancing knowledge and improving health. Is a reordering of priorities to emphasize these societal aims desirable or warranted?

Second, to what extent should the biomedical research enterprise acknowledge and respond to public pressures to produce immediate solutions to specific disease-related concerns? These understandable societal demands highlight the tension between investing in basic research to generate knowledge and investing in targeted research that is directed toward the cure of specific diseases. Debate must center on the extent to which biomedical research can and should be directed toward categorical disease themes, the degree to which it should be directly responsive to public pressures for specific disease initiatives, and the extent to which it should focus on translation of new knowledge into improved health care.

The Federal Role in Research Manpower and Training

The AAMC has traditionally maintained that a strong, viable program of research training is absolutely essential to ensure the quality and quantity of skilled scientists necessary to fulfill the nation's biomedical and biobehavioral research needs. The Association has continued to stress the need for a major federal role and reaffirmed the self-renewing nature of American research training, which yields highly trained investigators but also assures the critical core of academicians needed to sustain the cycle for the future. The AAMC has long endorsed the desirability of a diversity of support mechanisms for training with an emphasis on institutional training grants, which have education as the primary product and provide support for the training milieu. It has also emphasized efforts to attract more individuals

to careers in clinical research, and the desirability of a "generic" authority for research training under Section 301 of the Public Health Service Act.

The exponential expansion of the "new" biology requires of its investigators a depth of sophisticated knowledge and a high degree of technical capability, which are obtained only after a lengthy and rigorous program of research training. This is particularly true for clinical investigators, who must undertake both research and clinical training upon completion of their medical degrees. While affording a wealth of scientific opportunities, the demands that this increase in the depth and breadth of the biomedical research base place on the current research training mechanisms, and the resources needed to maintain an educational effort of this scope warrant a reexamination of the role of the federal government in support of biomedical and biobehavioral research education. This review should focus on the appropriate role and policies of NIH and ADAMHA in:

- stimulating interest in careers in science, particularly during baccalaureate and medical school education.
- insuring the necessary intensity and length of preparation for a research career as well as the breadth and flexibility needed to be productive in rapidly advancing disciplines.
- enhancing the adaptability of mid-career professionals in keeping abreast of changing research priorities.
- maintaining the appropriate elements of the training environment.
- ensuring the training of an appropriate number of M.D. investigators in the face of pressures generated by the increasing debt burden of medical graduates; efforts to limit support for subspecialty clinical training, and the difficulties of clinical investigators

and clinical research projects in competing successfully for grants.

- identifying and diminishing other career obstacles such as the National Research Service Award payback provision or the perception of instability in funding for meritorious investigators.

The AAMC Committee should also consider the role of the National Academy of Science Committee on Personnel Needs in Biomedical and Behavioral Research in setting the scale of federal investment in research training by its manpower projections. In particular it should consider the effects of the model used by the NAS committee to make manpower predictions. A model based on projections of available jobs leads to recommendations to expand the research training effort during periods of high federal investment in biomedical research and expanding enrollments in medical schools but would shrink that effort under current conditions. Should models that might project manpower needs based on anticipated scientific opportunities or numbers of qualified applicants for training be considered?

The Federal Research Award System

At issue in any examination of the present federal system advancing knowledge in the biomedical sciences to improve health are two aspects of the system for extramural research; the portfolio of grants or instruments used to invest in science and the system for allocation of the funds within and between components of this portfolio. The Association has traditionally maintained that a diverse portfolio is appropriate, with emphasis on individual investigator-initiated research grants, and that all levels of research should be supported with a greater emphasis on basic than targeted or applied research. Decisions regarding allocation of funds should be based on technical merit review, which incorporates judgments about scientific opportunity as well as the quality of the proposal and applicant.

The current system of allocating support for biomedical science is being subjected to a number of severe stresses. The quality of the grant applications submitted has increased, while the volume of applications is rising, thus necessitating more reviewers and involving heavier work loads for the initial review groups (IRGs). At the same time, the current economic climate imposes funding constraints that prevent the system, no matter how frenetically it struggles, from supporting all good proposals.

A disparity exists across the entire portfolio of funding mechanisms between these high quality proposals, with their inherent opportunities for scientific advancement, and the limited availability of financial resources to support these proposals. As a result, research funding is being increasingly dominated by a shift to individual project grants, with a three year funding cycle. This trend and the distortions it has produced in the grant application, grants portfolio, and review and funding processes necessitate an examination of the present system of research support.

For example, there is the perception that these pressures have caused the IRGs to become more conservative, stifling creativity by not supporting high risk proposals. There is a perception that the IRGs have recently tended more to reduce the budgets of individual grants. It is suggested that there are serious inadequacies with the process of scientific review; recently questions have been raised about the credibility of the reviewers, the validity of the grading system, and the integrity of the process itself.

There are concerns that this pressure on the grant application process also hampers research creativity by increasing the frequency, complexity, and multiplicity of applications, as well as increasing career instability for meritorious individual investigators. Lastly, there is the perception that

the system may be responding with a diminution of the heterogeneity and redundancy of project support that is both desirable and necessary in rapidly evolving areas of science.

Two policy questions arise out of this increased pressure on the system:

- What should be the diversity of the research portfolio and how can this be maintained?
- Is there evidence that the present system of competition based on project merit and expert judgment should be modified?

Federal Support for Institutional Infrastructure

The AAMC has long recognized the fragile ecology of the academic medical center and has continually advocated increased federal support for the structure and function of these institutions, which are responsible for the conduct of the majority of the nation's biomedical and biobehavioral research effort. This ecology, which is based on a delicate synergism of federal, state, and institutional resources, is being threatened by a variety of forces, such as the deterioration of the physical facilities, the obsolescence of instrumentation, the potential loss of income from patient care revenues, and federal and institutional bureaucratic accretion.

In an effort to provide support for the same number of grants with decreasing resources, the federal government has created a situation wherein it is widely believed that the research support dollar is increasingly directed toward procurement rather than investment; that is, that research is being "purchased", with little regard to the key elements of the infrastructure responsible for the research, such as support personnel, institutional training support, and facilities and equipment needs.

Beyond this question of whether the federal government should procure or invest in research are several other issues that require review by the AAMC ad hoc Committee on Research Policy. One is the appropriate locus for biomedical research; that is, what are the advantages and disadvantages of conducting biomedical research in academic medical centers, in partnership with industry, in autonomous research centers, or in the intramural programs at the NIH and ADAMHA? Is the present system of decentralization, which provides for a number of heterogeneous research units with the vast majority located in academic settings, desirable? Should there be more or fewer research centers? What needs to be done to strengthen these research centers?

Another important policy question is whether the current convention of distinguishing between "direct" and "indirect" research costs is the most efficacious mechanism for reimbursing the institutions for the costs related to the performance of research.

Federal Funding of Biomedical Research

The AAMC has traditionally espoused the essential role of adequate federal funding for biomedical and biobehavioral research in order to continue the scale of scientific effort that is currently established. The Association has also supported the concept that the amount of funding should be determined in part on the basis of "annual adjustments for inflation, for the increased cost of sophisticated investigative tools, and for investment in new and promising areas of research."

The tension between the scientific goal of exploiting new research opportunities and the economic goal of reducing federal obligations has resulted in efforts by both the Congress and the academic research community to determine what is the "optimum" amount of federal funding support for

biomedical research. These deliberations have focused on several policy questions; should biomedical research funding equal a fixed percentage of national health care costs or a percentage of the gross national product; should there be a requirement for annual growth; what would be the effects of curtailing federal funding for biomedical research, and has limited funding diminished the support of innovative or "high risk" research? Several other concepts that have been discussed are support for all good scientists or all meritorious projects, funding for a stable number of grants, and establishment of a base level of support for biomedical research.

At the same time, pressures continue to allocate funds to achieve other societal objectives, such as geographic diversity, health care delivery, or industrial competitiveness, which place even further strains on the availability of already limited fiscal resources.

The AAMC ad hoc Committee should consider which criteria are meaningful and appropriate for use in determining the amount of funding support that the federal government should supply for biomedical research. The "price tag" for desirable federal initiatives identified during previous committee discussions should be considered. The basis for recommending increased federal funding should be seriously debated in the light of the current economic realities.

Formulation of Federal Research Policy

Given the Association's positions in these five major policy areas, the AAMC ad hoc Committee should examine the process by which national policy for biomedical and biobehavioral research is formulated. Among the issues to be considered are the respective roles for the Congress, the administration (OSTP, OMB, and the Department of HHS), the agencies (NIH and ADAMHA), the institutions, the individual investigators, the voluntary health

organizations, and the public. At what level does each participant have a responsibility for the formulation of research policy? What should be the relationship between the participants, particularly in terms of oversight and providing appropriate checks and balances within the system? This is perhaps most critical in the interaction between the scientists, who possess expert judgment about scientific priorities, and the Congress, which is charged with the responsibility to represent the interests of the public. The tenor of Congress within the last decade has shifted increasingly to a view that scientists cannot be trusted to run the scientific enterprise: that they tenaciously defend the status quo against societal concerns and that they are suspect as expert witnesses because they are interested parties who stand only to gain from increased investment in an unfettered research enterprise. The clamor of single interest groups and their representatives for patchwork allocation of funds to narrowly targeted areas has grown steadily. This vox populi has increasingly emerged as a counterforce to decisions based on scientific judgment and research opportunity.

Other relationships also are changing. Historically, the Congress has had the primary task of establishing the broad brush strokes of research policy through the legislative and appropriations process, while the administration has fleshed out and implemented policy via the department and the individual agencies. Recently, however, various elements within the administration, most notably in OSTP and OMB, have attempted to assume a more central role in regard to biomedical research policy. At the same time, various public interest groups and even some academic disciplines and institutions have become much more direct in importuning the Congress or the administration to redirect research policy and funding. Thus, the changing roles of each of

these key groups interested in research policy should be a major concern to the AAMC Committee.

The discussions of who should set research policy at what level raise questions as to how these policy and funding allocation decisions should be evaluated or justified. As the federal investment in health research has grown, the pressure to provide "accountability" for the use of these funds also has increased. Congress and others wish to have more defined and measurable outcomes than the "improvement in the health of the American people" by which to judge the scope and merit of their investment in specific projects, programs, or theme areas of research. Various forms of fiscal accountability have increased during the last 10 to 20 years as a surrogate for a more "research planning" or goal directed approach to documenting the "pay-off" from the federal investment in research. However, the pressures to justify program investments or define outcomes tied to specific funding allocation continue. The AAMC Committee should consider to what extent accountability concepts should be applied to biomedical research.

The Committee should consider the extent to which a recent Association position paper "Preserving America's Preeminence in Medical Research" addresses these concerns or needs further development as an Association position on how science policy should be formulated.

INVESTIGATION OF THE VA INSPECTOR GENERAL
REGARDING CONFLICT OF INTEREST

Attached is background material relating to actions taken by the Veterans Administration Chief Medical Director in response to an investigation by the VA Inspector General. The first is a teletype sent to all regional directors, hospital directors, and all department of medicine and surgery field activities. Eighty-eight letters were sent to employees with actions ranging from reprimands to terminations. The second document is a reproduction of the federal regulations being cited dealing with standards of ethical conduct and related responsibilities of employees.

The AAMC staff is working with the VA Central Office in an attempt to clarify the issues involved. Dr. John Gronvall will join the CAS to discuss this matter.

TO: REGIONAL DIRECTORS: DIRECTORS, ALL DM&S FIELD ACTIVITIES

THE PURPOSE OF THIS MESSAGE IS TO EXPRESS MY DEEP CONCERN OVER DM&S EMPLOYEES ACCEPTING GRATUITIES, GIFTS, AND HONORARIA FROM DRUG COMPANIES OR OTHER COMPANIES AND INDIVIDUALS SEEKING TO DO OR CURRENTLY DOING BUSINESS WITH THE VETERANS ADMINISTRATION.

VA REGULATIONS ON EMPLOYEE CONDUCT AND OUTSIDE PROFESSIONAL ACTIVITIES CLEARLY AND SPECIFICALLY PROHIBIT AN EMPLOYEE FROM ENGAGING IN ANY ACTIVITY WHICH MAY BE CONSTRUED TO BE A CONFLICT OF INTEREST OR EVEN AN APPARENT CONFLICT OF INTEREST. THEY ALSO PROHIBIT EMPLOYEES OR THEIR FAMILIES FROM ACCEPTING, EITHER DIRECTLY OR INDIRECTLY, ANY GIFT, GRATUITY, FAVOR, ENTERTAINMENT, LOAN, OR ANYTHING OF MONETARY VALUE FROM A PERSON OR COMPANY THAT HAS, OR IS SEEKING CONTRACTUAL OR OTHER BUSINESS OR FINANCIAL RELATIONS WITH THE VA. IN ADDITION, VA EMPLOYEES ARE ALSO PROHIBITED FROM ENGAGING IN ANY ACTIVITY WHICH MIGHT RESULT IN OR CREATE THE APPEARANCE OF USING PUBLIC OFFICE FOR PRIVATE GAIN OR GIVING PREFERENTIAL TREATMENT TO ANY PERSON, GROUP, OR ORGANIZATION.

HONESTY, INTEGRITY, IMPARTIALITY, AND ETHICAL CONDUCT ON THE PART OF ALL EMPLOYEES ARE ESSENTIAL TO AN EFFECTIVE GOVERNMENT AND AN EFFECTIVE VA. AS CIVIL SERVANTS WE ARE ALL VESTED WITH A PUBLIC TRUST THAT MUST NOT BE COMPROMISED.

THEREFORE, AS CHIEF MEDICAL DIRECTOR, I WANT TO MAKE IT CLEAR THAT DISCIPLINARY ACTION WILL BE VIGOROUSLY PURSUED AGAINST ANY EMPLOYEE. NO MATTER WHAT LEVEL, WHO IMPROPERLY ACCEPTS OR CONDONES THE ACCEPTANCE OF ANY GIFT, GRATUITY OR HONORARIA IN VIOLATION OF APPROPRIATE LAWS AND VA REGULATIONS.

DIRECTORS ARE RESPONSIBLE FOR ENSURING THAT THIS MESSAGE IS DISSEMINATED TO ALL EMPLOYEES AND THAT EMPLOYEES ARE AWARE OF THE APPROPRIATE REGULATIONS GOVERNING STANDARDS OF ETHICAL CONDUCT AND OUTSIDE INCOME.

John W. Ditzler, M.D.
Chief Medical Director (10)
6/28/85

Following are the federal regulations being cited by VA officials in their letters charging VA employes with conflicts-of-interest as a result of the Smith Kline & French investigation:

**Standards of Ethical Conduct and Related
Responsibilities of Employes**

0.735-10 General Requirements

(a) Each Veterans Administration employe shall be expected to serve diligently, loyally and cooperatively; to exercise courtesy and dignity; and to conduct himself, both on and off duty, in a manner reflecting credit upon himself and the Veterans Administration.

(b) An employe shall avoid any action which might result in, or create the appearance of:

- (1) Using public office for private gain;
- (2) Giving preferential treatment to any person, group or organization;
- (3) Impeding government efficiency or economy;
- (4) Losing complete independence or impartiality;
- (5) Making a government decision outside official channels; or
- (6) Affecting adversely the confidence of the public in the integrity of the government.

(c) Employes shall not discriminate on the ground of race, color sex, religion or national origin in providing benefits under any law administered by the Veterans Administration. They shall not discriminate on those grounds or any other improper ground in any employment matter. Employes are responsible to cooperate in making equal opportunity for all a reality in the Veterans Administration.

(d) An employe shall not attempt to accomplish indirectly—through his immediate family or otherwise—any activity which he is prohibited from doing directly.

(e) Veterans Administration management and supervisors shall encourage the good conduct of employes by setting the example, by dealing with them considerately and impartially, and by showing sincere concern for them as individuals.

0.735-11 Gifts, entertainment and favors.

(a) Except as provided in paragraphs (b) and (f), of this section, an employe shall not solicit or accept directly or indirectly for himself or any member of his family, any gift, gratuity, favor, entertainment, loan or anything of monetary value, from a person (individual, corporation, company, association, firm, partnership, society, joint stock company, or any other organization or institution) who:

- (1) Has, or is seeking, contractual or other business or financial relations with the Veterans Administration;
- (2) Conducts operations or activities regulated by the Veterans Administration;
- (3) Has interests that may be substantially affected by the performance or nonperformance of his official duty; or
- (4) Is attempting to influence the employe's official actions.

(b) The restrictions set forth in paragraph (a) of this section do not apply when:

(1) It is clear that the motivating factor is the family or personal relationship (such as that between the employe and his parents, children, or spouse) rather than the business relationship of the persons concerned;

(2) Food and refreshments of nominal value are infrequently accepted when offered in the ordinary course of a coffee break, luncheon or dinner meeting, or other meeting, while on official business or on an inspection tour where an employe may properly be in attendance;

(3) Loans from banks or other financial institutions are sought on customary terms to finance proper and usual activities of employes, such as home mortgage loans;

(4) Advertising or promotional material is unsolicited and of nominal intrinsic value (such as pens, pencils, note pads, or calendars);

(5) Common courtesy gifts such as flowers are indicated on appropriate occasions.

(c) An employe shall not solicit a contribution from another employe for a gift to an official superior, make a donation as a gift to an official superior, or accept a gift from an employe receiving less pay than himself.... However, this paragraph does not prohibit a voluntary gift of nominal value or donation in a nominal amount made on a special occasion such as marriage, illness or retirement.

(d) An employe is prohibited from accepting gifts or gratuities such as goods, money, services, purchases at discount, entertainment or similar favors from claimants, patients, ex-patients, or other beneficiaries of the Veterans Administration, or their relatives, friends, or agents, since it could be interpreted that the favors are in return for official services rendered. The administrator may authorize exceptions to this prohibition where such action would not contravene the overall intent of this part.

(e) An employe shall not accept a gift, present, decoration or other thing from a foreign government unless authorized by Congress as provided by the Constitution and in 5 USC 7432.

(f) Neither this section nor 0.735-12 precludes an employe from receipt of bona fide reimbursement, unless prohibited by law for expenses of travel and such other necessary subsistence, as is compatible with this part for which no government payment or reimbursement is made. However, this paragraph does not allow an employe to be reimbursed, or payment to be made on his behalf, for excessive personal living expenses, gifts, entertainment, or other personal benefit, nor does it allow an employe to be reimbursed by a person (individual, corporation, company, association, firm, partnership, society, joint stock company, or any other organization or institution) for travel on official business under Veterans Administration orders when reimbursement is proscribed by Decision B-128527 of the Comptroller General dated March 7, 1967.

0.735-12 Outside employment, activity or compensation

(a) An employe shall not engage in outside employment or other outside activity not compatible with the full and proper discharge of the duties and responsibilities of his government employment. Incompatible activities include but are not limited to those which:

(1) Involve the acceptance of a fee, compensation, gift, payment or expense or any other thing of monetary value in circumstances in which acceptance may result in, or create the appearance of, conflicts of interest;

(2) Tend to impair his mental or physical capacity to perform his Veterans Administration duties and responsibilities in an acceptable manner;

(3) Bring discredit upon, are disadvantageous to, embarrass, or cause or may cause unfavorable and reasonable criticism of the federal government or the Veterans Administration;

(4) Conflict with the interests of the Veterans Administration or the federal government or can possibly be construed by the public to be official acts of the Veterans Administration;

(5) Involve the use of information obtained as a result of employment in the Veterans Administration, to the detriment of the Veterans Administration or those served by it;

(6) Take time or attention during duty hours, or consist of the private practice or a recognized profession to the extent that the employe appears to be privately practicing his profession during official duty hours;

(7) Violate a regulation, executive order, or a federal, state or local statute or ordinance.

(8) Tend to create suspicion of prejudice or favoritism in the administration of benefits to eligible veterans that could be of embarrassment to the Veterans Administration.

(b) An employe shall not receive any salary or anything of monetary value from a private source as compensation for his or her services to the government. This does not apply to employes working without compensation. (18 USC 209)

(c) Employes are encouraged to engage in teaching, lecturing and writing not prohibited by law, executive order...or any other agency policy. An employe shall not, however:

(1) Engage, with or without compensation, in teaching, lecturing or writing, including teaching, lecturing or writing for the purpose of the special preparation of a person or class of persons for an examination of the Civil Service Commission or of the Board of Examiners for the Foreign Service, that depends on information obtained as a result of his or her government employment, except when that information has been made available to the general public or will be made available on request, or when the administrator gives written authorization for the use of nonpublic information on the basis that the use is in the public interest;

(2) If he or she is a Presidential appointee covered by section 401(a) or Executive Order 11222, receive compensation, an honorarium or anything of monetary value for any consultation, lecture, discussion, writing or appearance, the subject matter of which is devoted substantially to the responsibilities, programs or operations of his agency, or which draws substantially on official data or ideas which have not become part of the body of public information;

(3) Accept any honorarium of more than \$2,000 (excluding amounts accepted for actual travel and subsistence expenses for such person and his or her spouse or an aide to such person, and excluding amounts paid or incurred for any agents' fees or commissions) for any appearance, speech or article, or honorariums aggregating more than \$25,000 in any calendar year....

(d) Employes are not prevented from:

(1) Receiving reimbursement in accordance with 0.735-11(f).

(2) Participating in the activities of national or state political parties not proscribed by law.

(3) Participating in the affairs of or accepting an award for a meritorious public contribution or achievement given by a charitable, religious, professional, social, fraternal, nonprofit educational and recreational, public service or civic organization.

(4) Engaging in outside employment permitted under this part.

(5) Taking part as a citizen or his or her community in civic, charitable, religious and other community efforts.

(e) Employes are encouraged to take part in service organization activities that do not conflict with, or give the appearance of conflicting with, Veterans Administration employment.

Thus, any employe may hold an office or position, at any level, provided that the combination of Veterans Administration position and service organization position cannot be construed as giving advantage to that organization, and if the employe agrees to disqualify himself or herself from taking part in any activities directed at the Veterans Administration, its policies, procedures or programs, or claims for benefits administered by the Veterans Administration. An employe may not act as a service officer preparing and presenting claims against the government.

Each employe is responsible for assuring that his or her intended actions are proper and, when in doubt, shall use the interpretation and advisory service established by 0.735-4. As used in this paragraph, a service organization is an organization usually composed of ex-servicemen, which presents claims from veterans and their dependents for benefits under laws administered by the Veterans Administration.

(f) An employe who engages in any outside work while on sick leave is required to report that fact to his or her supervisor.

(g) An employe shall not hold membership in any subversive organization or in a political party which advocates the overthrow of the government by force or violence.

AAMC AD HOC COMMITTEE ON FACULTY PRACTICE
STATEMENT OF CHARGE

The appointment of the ad hoc Committee on Faculty Practice was motivated by growing concerns among the AAMC constituency about the impact of changes in the health care delivery system on the ability of academic medical centers to fulfill their traditional missions of teaching, research, and patient care. Teaching hospitals have been the first to experience these changes and are actively engaged in re-positioning themselves in an environment of changing government reimbursement policies, price-consciousness, and growing commercialization. The AAMC has been active in representing the interests of these hospitals on policy issues and providing forums for exchange of information on how best to insure their survival amidst these currents.

The AAMC has had a less active and visible presence in assisting medical school faculties to cope with the new demands of purchasers of medical services. Its efforts have generally been limited to cataloging descriptions of faculty practice organization although grant-supported programs in the past have addressed the relationship between health maintenance organizations (HMO) and academic medical centers. Arguments in support of a renewed and more active effort are several:

- 1) the growing proportion of medical school revenues that faculty practice income represents;
- 2) rising concern that the commercialization of medical practice may be destructive of academic values and overshadow the academic mission of our institutions;
- 3) the emergence of HMOs and PPOs as a force in health care delivery mandating different organizational forms for providers of services;
- 4) a potential for growing division between physicians and hospitals created by changes in reimbursement policies and the movement to marketplace economics in health care delivery;
- 5) nagging skepticism that current governance mechanisms are adequate to respond to these challenges.

As with teaching hospitals, each medical school and its faculty practice organizations will have to decide on an institutional response to these developments. The AAMC has traditionally respected this autonomy of its member institutions. However, it is the feeling of many that there are initiatives that the AAMC could undertake that would help medical schools in this area.

Charge

The Committee is charged with the following:

- 1) to identify critical issues facing academic medical centers as a result of the changing practice environment;
- 2) to specify those issues in which the AAMC can and should have a role;
- 3) to recommend projects or programs the AAMC should undertake to assist its member institutions to deal with these issues.

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ISSUES RAISED BY THE FACULTY PRACTICE SURVEY AND
QUESTIONS FOR DISCUSSION

The results of the AAMC Faculty Practice Survey highlight a number of interrelated issues that respondents believed to be critical to their institution's faculty practice activity. Below is a further distillation of the main issues raised and related questions which might serve as a basis for the committee's discussion. With respect to each of these areas, the committee needs to identify the specific issues involved and roles for the AAMC in serving its members.

Dependence on Practice Income

Most observers agree that medical schools are increasingly dependent upon patient care revenue for their fiscal viability.

*Ronald R. Kaufman
HMOs and AMCs - A Status
Report, 1984*

Respondents to the survey suggested that schools are in different positions with respect to the kind of problem this may represent. Some expressed concern that this dependence on practice income to support school and department budgets has become too great while others suggested that practice income represented a not yet fully-exploited source to replace other funds now becoming increasingly constrained. A cursory review of the data indicates that practice income is a significant and growing percentage of total revenues or general operating revenues. The growth in this source of support has paralleled the growth in

size of full-time faculties and faculty practice plans. Since the income-generating ability of clinical faculty varies by specialty, some departments are more able than others to provide a surplus (exclusive of direct physician compensation, fringe benefits, and operating expenses) to support education and research activities. Section V of this background book contains a review of AAMC data showing different perspectives on the dependence issue.

- To what extent is the medical school's dependence on practice income a concern for the AAMC and its members?
- Do changes in reimbursement policies and increased competition in the medical care system threaten medical schools? Medical faculties? Teaching hospitals? If so, in what ways are these threats similar or different for each? Is the AAMC sufficiently cognizant of and responsive to these threats?
- Does the AAMC have adequate monitoring and reporting systems to serve its members' interests?
- What are the consequences of decreased service income as a result of changing reimbursement policies and increased competition for the medical school's academic programs?

Preserving Academic Mission

To survive, [teaching hospitals] must consider several alternatives to meet the new challenges.... To some extent, each increases the commercialization of the enterprise and could threaten the traditional

balance of education, research, and service functions of the academic medical center.

*John A. D. Cooper
JME, Jan. 1982*

As generation of professional fee income becomes increasingly important for individual and special groups of full-time faculty, it follows that their commitment to and time spent in real medical school pursuits -- teaching and research -- will decline.

*Leighton E. Cluff
JAMA, Dec. 1983*

A consequence of this increased emphasis on practice and of the increasing size of the faculty is that it has placed many academic departments on a treadmill. As they get busier, they need more help.... I wonder, however, whether the change in ambience in which teaching and research take a back seat to practice should be driving medical schools.

*Robert G. Petersdorf
JAMA, May 3, 1985*

The perceived need for increased clinical income to support medical school programs, financial incentive systems that reward practice activity, and the need to maintain or increase the census of teaching hospitals are encouraging faculty to spend more and more time in practice. Fiscal concerns are not the only driving force. There is a fear that the changing practice environment is threatening the patient base needed for educational and research programs. The apportionment of faculty time was ranked as the most frequently mentioned issue by all but one of the groups surveyed. Some survey respondents see practice demands detracting from the teaching and research missions of the school. Others feel that survival depends on clinical faculty

being more active and involved in practice, and that active clinical practice and teaching (if not research) are supportive of each other. (The affirmative responses to the survey question regarding the perceived conflict between clinical practice and the academic mission ranged from a low of 35 percent to a high of 68 percent.)

- Have these (and other) commentators identified a problem to which the AAMC should be responsive?
- In what ways can the AAMC assist its members to preserve their academic missions?
- Are our members adequately informed about the nature and significance of increased competition in the practice environment? Do they have access to strategies for coping successfully?

Faculty Appointments

The concept of full-time clinical faculty today has little resemblance to that enunciated by Flexner and adopted by most medical schools several decades ago. As initially defined, "full-time staff are so salaried that the hospitals and medical school command their entire time for the care of patients, for the instruction of students, and for research.... He is simply freed from the necessity of earning any part of his livelihood by private and consulting practice -- free that is, to devote himself in what is for him the most effective fashion to the care of patients, the training of pupils and the increase of knowledge."

Leighton E. Cluff
(Quoting Flexner)
JAMA, Dec. 2, 1983

We need to reintroduce the use of part-time faculty, either paid or unpaid. It is no longer sensible or wise for medical schools to have full-time people in every specialty or subspecialty. The volume of business simply does not warrant it. Part-time faculty have the advantage of practice experience.... They do

not require laboratory space and rarely require offices or other support systems. They will save the medical school money and, with proper leadership, will constitute valuable teaching and training resources for both medical students and house staff.

*Robert G. Petersdorf
JAMA, May 3, 1985*

These commentators suggest that a change in conception of the full-time faculty and the role of the part-time faculty would both ease the financial pressures on the school and increase the focus on the academic enterprise.

- Does it make sense for the AAMC to take a public position encouraging deliberation on such proposals?
- Is there a way in which these approaches could be tested and the results monitored for the benefit of the membership?

To handle the already heavy practice load that has evolved on medical schools, it is essential that they recruit a second faculty of clinician-teachers in addition to the traditional researchers. In recruiting such faculty, the schools must accept that this second faculty will differ from their more research-oriented colleagues. In fact, they make up one platoon in a two-platoon system.... Both [platoons] will be academic, and both should insist on scholarship, but both are necessary.

*Robert G. Petersdorf
JAMA, May 3, 1985*

So far, the experience at the University of Pennsylvania has been that the clinician-educator faculty members seem to feel as secure in their positions as tenured faculty members.

*Edward J. Stemmler
JME, June 1984*

There seems to have been an imbalance in the rewards in favor of basic research compared to clinical activity. The clinician often is perceived as a second class citizen despite a great deal of rhetoric to the contrary. The young faculty members all recognize this status and are offended by it.... (G)iven the high service load placed on them for clinical activities and the lack of free time to do clinical research, they are routinely going into private practice.

Hospital Director
Respondent, AAMC Faculty
Practice Survey

- Does the model of the two-platoon system: clinician-educators and researcher-teachers with varying appointment, promotion, and tenure policies reflecting their respective contributions present an attractive alternative to current practice?
- Would it create or resolve the second class citizenship problem?
- Does it support or compromise the standards of scholarship of the university faculty?

Faculty-Hospital Relationships

In our culture it is customary for physicians, including academic physicians, to think of the financial difficulties faced by the hospital as someone else's problem.

Robert Ebert
NEJM, May 19, 1983

The symbiosis of the medical school and its primary clinical affiliate, which have been a major source of strength during the long era of prosperity, may turn into a hindrance, if not a fatal liability, for the hospital in the years ahead.... It is far from clear that the medical school faculty is the most

suitable, much less the only, party to such [necessary] restructuring.

Eli Ginzberg
Health Affairs, Summer 1985

The future competition in health care will not be between doctors and hospitals, or between hospitals and other hospitals, or between doctors and other doctors. Rather, the competition will be between groups of doctors and hospitals and other groups of doctors and hospitals.

Michael D. Bromberg
Review, December 1984

Unfortunately, the regulatory environment has focused (at least to date) principally on the hospital; it has put the hospital (the enforcer of regulations) increasingly at odds with its physicians and increasingly at risk for the consequences of their clinical practice.

Vice Chancellor for Health
Affairs and Hospital CEO
Respondent, AAMC Faculty
Practice Survey,

Rather than working toward a common mission and set of goals and objectives for the AHC, the faculty practice plan is doing what's best for itself and the hospital is doing the same. Thus, we find ourselves competing against one another and the faculty practice plan beginning to set up services/programs in direct competition with the university hospital.

Vice Chancellor and Hospital
Director
Respondent, AAMC Faculty
Practice Survey, 1985

Hospital directors responding to the AAMC Faculty Practice Survey placed the matter of hospital-faculty relationships at the top of their agenda. They recognized and were sensitive to the

academic mission. They appreciated the potential for conflict between traditional faculty values and the demands of competition. They perceived little comparable sensitivity on the part of faculty who seemed either to be oblivious to the need to change or to be charging off to advance their own interests.

- Are we as a community as vulnerable and in such disarray as these commentators suggest?
- Are there undertakings at the national level which will assist in local recognition of the problem? In motivating the parties to action? In setting out the framework of effective strategies to follow?

Practice Organization

A new survey of medical group practice conducted by the AMA's Division of Survey and Data Resources reported a rapid rise in the number of groups in less than five years. In the last nineteen years, the number of identified group practices has nearly quadrupled from 4,289 to 15,484.... Most groups (5,579 of the 1984 total) are comprised of 3 or 4 physicians, but the number of groups with 100 or more physicians is growing too; there were 76 such groups four years ago and by 1984 the number had increased to 158. One force driving physicians to cluster in groups is a concern that they be well positioned to compete for patients in the future.

*David A. Crozier and John K.
Iglehart
Health Affairs, Winter 1984*

The other side of the coin is that academic faculties need to form true group practices to meet the competition. In order to achieve this goal, the traditional and often confining practices based on the academic departmental structure are probably not the way of the future.

*Robert G. Petersdorf, M.D.
JAMA, May 3, 1985*

In my opinion, the clinical practice of our faculty must be viewed as a large group practice rather than a confederation of individual clinical departments.... In addition, the group must have a governing body which is able to negotiate with outside parties to deliver a total health care product at a competitive price.

*Faculty Representative,
Respondent, AAMC Faculty
Practice Survey*

Since it [faculty practice plan] is departmentally organized, the departments themselves are not well positioned to meet the market with too few general internists and too many specialists, etc.

*Hospital Director
responding to the AAMC
Faculty Practice Survey*

It is important that some institutional philosophy be developed that neither permits exploitation of the institution by individual clinical departments nor gives a free ride to parts of the academic health center that are remote from the concerns of the medical school and the teaching hospital. That means that the practice should be a multispecialty group practice that plans its staffing on the basis of the needs of the multispecialty group instead of those of the department.

*Robert H. Ebert, and
Sarah Brown
NEJM, May 19, 1983*

Medical and health services are increasingly available through brokered systems in which the buyers are no longer interested in purchasing separately physician services or hospital services but rather are seeking the guaranteed availability of necessary medical services at a predetermined fixed price. This development is undoubtedly spurring the growth of group practices as described above. It also is the source of frequent statements

in the AAMC Faculty Practice Survey that medical school faculties need to re-organize their practice activities along interdisciplinary lines and form a "true group practice." While the definition of a true group practice is not clear, apparently several characteristics need to be present: the coordinated management of patients, internal referral systems, income sharing arrangements that recognize the contribution of each member to the group, and mechanisms to develop joint ventures with hospitals and negotiate with prepaid managed care systems.

- Is there a need for re-organized practice arrangements in academic medical centers?
- Do medical schools need to re-organize their practice plans into multidisciplinary groups?
- Is there an appropriate model for this re-organized arrangement currently in an academic medical center?
- What are the main obstacles to such a re-organization?
- What could the AAMC do to help centers surmount these obstacles?
- Should the AAMC develop educational programs addressing the re-organization of practice plans?
- Should the AAMC serve as a resource center to provide periodic reports on the current characteristics of practice plans?

Governance

Many of the preceding issues are inextricably entwined with governance mechanisms in academic medical centers and the

relationships among the department chairmen, dean, hospital director, and vice-president. While strong departmental structures have been a source of strength of American medical schools, there is a fear that their relative autonomy hinders effective action on a number of problems facing academic medical centers. Several observers have commented on the autonomy of many department chairmen:

We noted earlier that in the years of open-handed funding for medical research and GME, power shifted from the deans to departmental chairmen and principal investigators. It will not be easy for medical schools to reverse this trend, but if they are to respond to the many critical needs that have been identified, from reforming the curriculum to implementing constructive personnel policies that will assure a vital faculty, a strengthening of the central medical school administration is essential.

*Eli Ginzberg
Health Affairs, Summer 1985*

(T)his new income is not evenly distributed. "Those who earned the most acquired the most power on medical school faculties," Cluff noted. At one institution with which he was familiar, the departments of radiology and ophthalmology were "generating so much income that the department of medicine, which was providing 32 percent of all teaching in the medical school, to a large extent lost most of its influence and power.... This had profound effects on the educational process," Cluff said, "and I don't think we should over look it."

*Richard A. Knox
(Quoting Leighton Cluff),
Health Affairs, Summer, 1985*

It is our contention that academic departments can no longer function each as "a tub on its own bottom, sailing in whatever direction it wishes." Indeed, if administrative anarchy is to be avoided, the multiple

demands on the medical school and hospital must be addressed through coordinated actions.

*Robert G. Petersdorf and
Marjorie P. Wilson
JAMA, February 26, 1982*

There is perceived to be a danger that unfettered departmental autonomy in the practice arena results in a variety of separately negotiated arrangements which strengthen individual departments but do not advance the institutional mission.

- Is this danger real and growing?
- Are current governance mechanisms adequate to cope with this trend?

Perhaps the experience of medical schools in the development of NIH-funded research centers provides an analogue to the problems in developing interdisciplinary practice organizations.

These large and complex programs [NIH funded research centers] have specific management, personnel and resource requirements which are not entirely congruent with those of the educational institutions in which many of them are best housed.... A... problem is the occurrence of branched or ambiguous lines of institutional authority. Centers and targeted research create new intra- and extra-institutional constituencies to which institutional systems of governance must adapt. This is often reflected in the creation of a center advisory board which does not fit into the institutional decision-making procedure.

*Stuart Bondurant
Presentation to the President's
Biomedical Research Panel,
1975*

- Are there lessons to be learned from the history of NIH-funded research centers in academic medicine that

apply to the governance issues surrounding the development of an interdisciplinary practice organization?

Governance mechanisms that encourage departments to function in the service of medical school objectives are not sufficient. Competition and regulation make visible the interdependency of medical schools and their teaching hospitals. These highlight the need for coordinated medical center wide strategies that recognize the different businesses medical schools and teaching hospitals are in.

It is not unusual for the hospital director to disagree with the medical staff on the one hand and the medical school administration on the other. Such conflicts must be brought into the open to be resolved.... The director must do more than keep his eye on the bottom line, and the dean must view the hospital as more than a laboratory for research and a classroom for teaching.

*Robert G. Petersdorf and
Marjorie Wilson,
JAMA, February 26, 1982*

The real question is how to conduct, direct, and manage the complex of institutions engaged in different businesses that make up an academic medical center. There is a need to define the market for the businesses, that is, the consumers and their expectations.... They are the most important people -- not deans, directors, vice presidents or faculties.

*Robert M. Heyssel
JME, March 1984*

Traditionally, faculty have been encouraged in their entrepreneurship and much of the growth of the system may be attributed to the success of their efforts. Academically, a substantial level of autonomy has been regarded as essential to the creative and scholarly missions of academic medicine. Now, however, it appears that changed financial incentives in the

practice arenas as well as the potential need for better management of the size and content of the educational program at both the graduate and undergraduate levels, raise the question of whether our institutional structures and processes are equal to the task of institutional management.

From the AAMC Officer's
Retreat Agenda, December
1983

- How will strategic decisions affecting the medical school and hospital be made?
 - What is the role of the dean?
 - What is the role of the department chairman?
 - What is the role of the hospital chief executive officer?
 - What is the role of the vice president?
 - What options are available?
- How can the academic model of governance in the medical school be reconciled with the corporate model in the hospital to set strategy for the medical center?
- In what ways can the AAMC assist its members in exploring these options and developing strategy?

Prepaid Managed Care Systems

While the patient, government, and insurance carriers have been unable to prevent the increase in health care costs, they are now prepared to mandate that the physician accept the responsibility for constraining them. In those areas where physicians are already in over supply, they are agreeing to assure this burden. Medical centers in such areas must be prepared to either form large HMOs and/or develop very strong referral programs.

R. B. Friedman
JME, July 1984

...There will be attempts at vertical integration resulting in "brand name medicine," in which different levels of care are furnished under a single name, sophisticated marketing and sales operations are the rule, and patients are locked into a health provision system from birth to death for anything from one-shot emergencies to long-term geriatric care... Given the academic medical center's lack of price competitiveness, as a consequence of teaching costs, an unusually high incidence of indigent patients, and a preponderance of sick patients, this change in environment represents a very real threat to their fiscal solvency and perhaps even their academic viability.

Robert G. Petersdorf
JAMA, May 1985

As described above, competition for patients by hospitals and practitioners is on the rise and price is an increasingly important factor in purchasing decisions by patients. HMOs and PPOs are rapidly emerging in the health care delivery system and will lock an increasing percentage of the population into closed panels. Academic medical centers for their own survival may have to negotiate for referrals from HMOs or sponsor their own in order to have access to these patients. Association with or sponsorship of an HMO raises a number of problems which must be addressed and resolved:

There are several conclusions that most observers have drawn from past medical school/HMO affiliations. They are:

- (1) *The initial development of a HMO requires substantial capital investment...*
- (2) *Faculty physicians have difficulty functioning in the HMO environment. A common difficulty in establishing an HMO in an academic setting is the need to set productivity standards that interfere with teaching or run counter to faculty attitudes. A related problem is the difficulty of finding sources*

of funds to subsidize the teaching cost of an HMO...

Bernard W. Nelson
HMOs and AMCs - A Status
Report, 1984

To date, HMOs have shown considerably more interest in participating in graduate rather than undergraduate medical training. At the graduate level HMOs receive the service benefits of residents' clinical participation and may recruit these residents for their staffs. Involvement in undergraduate medical education, on the other hand, is generally viewed by HMOs as a more costly proposition. Medical students offer limited service benefits and require more instructional time from staff physicians.

Joseph Isaacs
HMOs and AMCs - A Status
Report, 1984

- What changes are required for a medical center to become a part of HMO referral systems?
- Is an academic medical centered-sponsored HMO viable?
- What are effective models of medical center-HMO affiliations?
- Can the concept of risk-sharing, inherent in the new modes of medical care delivery, be integrated with faculty practice organizations and hospital systems under university and/or state control?

...the academic medical center must realize that the sponsorship of an HMO requires a major commitment to develop well-organized and effective primary-care services and that only after substantial growth will the HMO membership contribute noticeably to the use of the existing secondary- and tertiary-care services of the academic medical center.

Richard H. Hoft and
Robert J. Glaser
NEJM, December 30, 1982

Historically, medical schools and teaching hospitals have emphasized secondary and tertiary services over primary care. The sponsorship of an HMO would seem to require new faculty staffing patterns. Other developments, such as outreach satellite clinics, are also pushing medical schools and teaching hospitals to expand primary care services to ensure the referral system which is threatened by greater involvement of community physicians and hospitals in specialized services, formerly the exclusive province of the academic medical center.

- Is the medical school faculty organized and staffed in a way to deliver primary care?
- What are the implications of greater primary care emphasis for staffing patterns and educational programs?
- Are there different strategies taken by medical schools and teaching hospitals to preserve a referral system?
- Is there assistance that the AAMC can provide schools in deciding on a strategy.

The AAMC is currently planning four regional workshops addressing alternative delivery systems and the challenges posed to academic medical centers. At the first meeting of the committee, a description of these seminars will be presented.

- Are there additional activities or efforts the AAMC should undertake to assist its members in understanding the complexities of these ventures?

Practice Plan Management

To be competitive and maintain their market share, AMCs will have to spend more of their resources on

developing professional managers...and on other expertise needed to promote their faculty practice plans and/or alternative delivery systems.

Ronald Kaufman
HMO's and AMC's - A Status
Report, 1984

The changes in the health care delivery system have increased the importance of professionals in the field of health care management and organization. The AAMC has had extensive involvement with hospital directors but a less visible involvement with faculty practice plan administrators. The AAMC's involvement with hospital directors is based on its mission of representing them on broad national policy issues affecting teaching hospitals and not on increasing their expertise in hospital management. Since practice plan managers have not been formally recognized as those directly responsible for policy setting, the AAMC has not supported their activities in a similar fashion. However, the complexity of practice management today has given practice plan administrators an influential role in the development of policy because of the technical expertise these administrators bring to questions of physician reimbursement, new practice organizations and joint venture arrangements, etc. The Medical Group Management Association Academic Practice Assembly (MGMA-APA) has emerged as the principal professional development organization for these administrators. Some participate in the activities of the AAMC's Group on Business Affairs (GBA) but that group traditionally has served the needs of medical school financial and business officers. (See Section VII for a description of these organizations).

- Should the AAMC make a more concerted, direct, and visible effort to involve practice plan administrators in its activities?
- What form should this new initiative take?
- Should the AAMC consider developing a relationship with MGMA-APA?

TRANSITION TO GRADUATE MEDICAL EDUCATION

Concern continues to be expressed from many quarters regarding the increasing pressures that the processes of residency selection are placing on medical education. Within the last year many factors contributing to these pressures have been identified. These include the administrative and logistical burdens which the increasing scale and complexity of the process are imposing on students, student affairs offices and faculty. In addition, distortions of the sequence and timing of the clerkships due to premature pressures to make specialty career choices, inadequacies in the career counseling process, and confusions engendered by the timing and multiplicity of residency matches have all been cited as part of the problem. The Council of Deans has continued to discuss issues surrounding the residency selection process during this past year and has consulted with both the Group on Medical Education and the Group on Student Affairs. The CAS-COD working group that prepared the Association commentary on the GPEP report devoted considerable attention to these pressures on the students' general education. As increasing numbers of people have focused on examining the current process of transition to graduate medical education, all have gained insight into its complexity and the multiplicity of issues which must be addressed to achieve a successful resolution of the stresses. It has also become clear that many different groups must work together to achieve any desired change.

Further deliberations at the Annual Meeting will include a special session of the Council of Deans and a combined session of the GSA-GME on Wednesday morning devoted to this topic. These meetings have been aided by an issues paper prepared by the leadership of the Groups on Student Affairs and Medical Education, which is attached. This paper explicitly identifies issues in three key phases of the transition to graduate medical education, attempts to clearly acknowledge the complexity and interrelatedness of the many facets of the process, and proposes possible solutions to some of the specific concerns identified. An example of such a proposal is the suggestion that the present chaos could be reduced by the institution of a common, centralized application system modeled after the AMCAS. A further background paper, which was provided to the Council of Deans, is also included for your information. It was originally prepared by Philip W. Felts, M.D. of the Office of Student Affairs at Vanderbilt, for the Southern Deans Meeting. The GME Editorial he mentions is also appended.

The Executive Council of the Association discussed at its September meeting the advisability of forming an ad hoc AAMC committee to examine these issues and considered the merit of joining with other concerned national groups such as the Council of Medical Specialty Societies and the ACGME in forging solutions.

TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

A Report to the
Administrative Boards
Association of American Medical Colleges
September 11-12, 1985

Developed from an Analysis by:
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TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

I. Graduate Medical Education and the Selection Process

A. Issues

A number of recurring questions and concerns center around the selection process and the associated matches:

- o With the limitation in positions, do program directors need to begin to define the population to whom they will give major consideration in the selection process?
- o We have yet to see the impact of the for profit hospital corporations on the recruitment and selection of medical students for positions funded by those corporations in certain medical centers.
- o Does any organization have the right to prevent, restrict or constrain any groups of individuals from establishing their own match process? Will the for profit hospital corporations move in that direction?
- o The NRMP has been in continual evolution since the late 1950's; does the system need further revision to accommodate contemporary needs?

Consideration of these questions and concerns have led to the identification of the following problem list for the graduate medical education selection process:

1. Too much splintering of specialty interest groups into their own match processes: Colenbrander matches, military matches, Urology match, and individual hospital or specialties which operate outside the boundaries of any match process (the no-match group).
2. No uniformity of applications. Some programs use the uniform application, while others use one that has been developed by their own hospitals. This creates enormous pressures on students who may need to submit 30 to 50 applications to one, two, or more specialties.
3. Points of entry into graduate training are many and varied, leading to massive communication problems for all participants.
4. The algorithm and terminology of the NRMP are complex and not easily understood even by the most experienced.

5. In the competitive specialty programs, selection committees are insisting that candidates come for interviews (without any assurances) in order to be given consideration.
6. There is no composite information on available options through all forms of selection processes. This leads to difficulties in communication about entry points for postgraduate training. Each entity administering a match carries out its own form of advertising.

B. Suggestions

Short Term Changes

1. Request that NRMP review and evaluate current information that is being disseminated to program directors and students, including descriptions of the match algorithm and the types of positions offered.
2. There is a definite need for some entity (perhaps the AAMC) to develop comprehensive materials on the residency selection process. A prototype example might be the Medical School Admission Requirements handbook. Explore how this information can or should be communicated.

Long Term Changes

3. Consider a thorough examination and evaluation of the current NRMP process and staffing needs. The NRMP Board of Directors is the group with this responsibility. Perhaps the recently created advisory board could work with the NRMP to provide input from each specialty.
4. Consider development of centralized application service. While there is a uniform application, there is no agreed upon useage. If the program directors could be furnished a reduced administrative workload through such a service (e.g. AMCAS), the system could become sufficiently widely used to furnish a basis for the development of "traffic rules" (e.g. uniform dates).
5. Develop materials by specialty (including details of specific programs within each specialty) which could be sold at cost to students. Such materials should include the following types of information:
 - a. Types of candidates that each program seeks. If possible, a greater specificity about the range of backgrounds sought: LCME graduates only, East coast schools only, AOA, National Board Part I scores of 550 or better, etc. This could reduce the "shot-gun" approach to program selection which currently exists and could markedly reduce the work-load of all parties concerned. If a book of this type is to be developed,

program directors must be convinced that it helps them cut their own costs of communication, and reduces their work load.

- b. Range of stipend. This may become increasingly important as students amass high debts. Students will need to know if they can afford particular programs.
 - c. Range of benefits - malpractice insurance, health benefits, etc.
 - d. Expected background -- "desirable to have electives in....."
 - e. How the interview process is administered.
 - f. Whether they have special programs: primary care track, research track, and other special features of the program.
6. Have teaching hospital directors assume authority over the recruitment and selection procedures of the programs sponsored by their institutions. The diversity of specialties and the sheer number of programs (over 5,000) makes the achievement of uniform policies and procedures almost impossible. In addition, the development of useful information about institutions' programs for students would be simplified if reliable communications were established with the institutions that sponsor programs rather than with each program director. The AAMC has pressed for greater institutional responsibility for graduate medical education since the late 1960s. The assumption of authority over recruitment and selection policies and procedures by the directors of COH member hospitals, which provide more than 60 percent of residency positions, could set a precedent that other hospitals would follow.

II. Graduate Medical Education and the Clinical Curriculum

A. Issues

Another major dimension of the transition process is its impact on the clinical education of the medical student, as is evidenced by the following questions and concerns:

- o Do residency directors unduly influence the medical school curriculum now that students are being recruited and selected as early as the third year?
- o Are program directors suggesting (or even stating) to students that unless they take an elective in their hospital, they will not be interviewed or fully considered for a position?
- o Has the use of external examination scores (NBME Parts I and II) become a major selection factor, when it is known that

these scores measure only a small fraction of the attributes necessary for the practice of quality medicine?

A careful review of these and related questions lead us to the following delineation of problems in the clinical education of medical students:

1. Students seeking positions in the very competitive specialties (particularly the surgical specialties, but also, ophthalmology and emergency medicine) are reported to be taking three and four identical electives in the specialty area of choice at various hospitals in the hope of bettering their selection chances. This compromises the general professional education of the physician.
2. A good portion of the fall of the senior year is devoted to completing multiple applications and seeking interviews. There appears to be little interest in assisting the students by grouping interviews for traveling to a particular region of the country. Often times students must make multiple trips back to an area because of the inflexibility of the interview process.
3. The cost of travel associated with the selection process discriminates against less affluent students and, if incorporated in the approved educational costs, increases their indebtedness.
4. The focus on education and learning is being lost in the increasing emphasis on preparing for the residency selection process.
5. Schools are being forced to change their third year curricular structures to accommodate pressures on their students for early exposure to various specialties. Similar pressures in the fourth year are acting to distort elective programs as students undertake earlier specialization.
6. Earlier selection and preparation for selection are forcing premature decisions about career choices upon students.
7. Because low or average NBME scores may preclude a student from being interviewed, schools now need to furnish considerable time for students to prepare for and/or to provide support services to assist them in preparation for these examinations.
8. The pressure upon schools to place their graduates is causing a grade inflation problem, thus lessening the credibility of grades as a measure of competence.

B. Suggestions

Short Term Changes

1. Ask the program directors to work with the AAMC to facilitate communication with medical schools: traffic rules, general guidelines, uniform applications, interview time frames.
2. Undertake research to determine which selection factors provide the best residents. This may increase the quality of selection factors beyond those now currently being used.

Long Term Changes

3. Reduce the number of medical students commensurate with the reduction in residency positions.
4. Development of an examination of clinical skills which is both more comprehensive and more oriented to problem solving. Such an examination might well include a "hands on" performance evaluation.
5. Consider a fifth year of medical school. By the fifth year, students would have narrowed their specialty interest to three and would spend three months in each area. The three remaining months of that year would be devoted to a Match process with high quality evaluation techniques being utilized to provide maximum information about the students' skills, abilities and suitability for a particular professional area.
6. Consider extending medical school through four years of clinical education, incorporating residency training into the fourth, fifth, and sixth years of a pre M.D. program.

III. Graduate Medical Education and the Counseling Process

A. Issues

A third series of questions and concerns exemplify another area affected by the transition: the role of Deans of Student Affairs and the problems of counseling in residency selection.

- o In transmitting information to program directors, should Deans of Student Affairs be a student advocate or a factual reporter? Do they have an obligation to see that all medical students have a graduate medical education position?
- o In times of more limited resources, Deans of Student Affairs are being asked to take on greater responsibilities in the residency placement process, including working with graduates who are one, two, or more years out of medical school. How far in time does institutional responsibility extend?
- o What responsibility does an institution have to develop a comprehensive advising system? Should such a system include financial planning and debt counseling since graduates may

have debts which are excessive in relation to residency salaries?

- o Advising is a demanding job and advisors need to have broad knowledge of programs, hospitals, specialties, understanding of selection factors and knowledge of financial matters. Is it realistic to expect our medical schools to expand the staffing for these advising functions?

These questions suggest the following problem areas which might be addressed:

1. In the past, medical students have usually been able to obtain a position in the specialty they wanted. Now, with fewer positions available, Deans of Student Affairs are being placed increasingly in the position of encouraging students to apply for two or three specialties. This emphasis on getting students placed, comes at the expense of the "career fit" counseling process.
2. A related problem with yet to be determined consequences is the possible effect of reduced funding for graduate medical education on the remuneration available and the possibility of significant variation in compensation levels.
3. Early Deans' letters for special matches often require supplemental letters for subsequent matches, compounding the administrative load.
4. Training new and or part-time Deans of Student Affairs in the development of counseling systems and in keeping up with changes in the selection process.
5. Advising the students who find themselves in difficult ethical dilemmas regarding match situations. The ethics of the marketplace appears to be prevailing, and the sense that anything goes is creating major problems with agreements about current procedural guidelines. This is particularly true for the unmatched student who is seeking a competitive specialty. When very few places are available, the temptation to cheat increases.
6. Helping students reduce the anxieties involved in a competitive selection process where their years of work may not achieve a result supportive of their career goals. This may contribute to a loss of idealism about the practice of medicine and about themselves as practicing physicians.

B. Suggestions

1. Offer a national institute where program directors, Student Affairs Deans, and selected students can meet to develop some strategies and goals for increasing the effectiveness of the selection process.

2. Develop a network of Deans of Student Affairs (computer bulletin board?) to provide a means for updating certain kinds of information. Such a network has been proposed by the NRMP for listing unfilled places throughout the year. This type of network might be extended more fully to provide a greater array of services through the NRMP office.

Prepared for the Southern Council of Deans Meeting
September 21, 1985

By Philip W. Felts, M.D.
Assistant Dean for Student Affairs
Vanderbilt University School of Medicine

"Transitionitis"

Preparing for the transition into internship and residency training has been labeled the "pre-residency syndrome" by Gus Swanson in his terse but thoughtful editorial in the Journal of Medical Education for March, 1985. Therein, he calls upon specialty boards and residency review committees to mend their ways and provide relief for the Fourth Year medical student in this country. While awaiting any initiative on their part, the DEANS in this country can take steps to help alleviate some the problems program directors have created. Towards that end, this presentation is made.

"Transitionosis" as the more specific diagnostic label was considered, and the condition does have some of the characteristics of metastatic malignancy. The term "transitionitis," however, seems more appropriate since this is epidemic in proportion and acute in nature but both curable and preventable. The DEANS' therapeutic intervention is urgently indicated. Some problems are presented followed by possible solutions.

What we have lost from the Fourth Year educational experience:

By virtue of the residency-seeking process as it now operates, no longer is it feasible for Fourth Year medical students to use:

- ◆ their third summer in medical school for research;
- ◆ their third summer and early fall academic units for clinical experiences (clerkships) to help decide among fields of potential interest;
- ◆ their Fourth Year for general professional education, emphasizing areas other than their intended field of specialization;
- ◆ their Fourth Year in imaginative and innovative ways to broaden their education and enhance the liberal and humanistic side of their education.

What we have instead in the Fourth Year:

Not only have we lost the above, but no longer can Fourth Year students approach the transition into residency training in an orderly, deliberate and thoughtful manner. Instead, what we have is a group of students:

- ◆ who have to spend half of their Fourth Year in a high state of anxiety and frustration;
- ◆ who have to spend time in visiting clerkships as a prerequisite even to be considered for a particular residency program with the attendant costs in terms of time applying, arranging temporary housing, paying registrations fees and/or tuition, and the dollar expense of all of it;

- ◆ who have to spend a great deal of time and money in filling out applications, trying to schedule interviews, traveling to interviews, being interviewed, and paying for all of it;
- ◆ who have to compromise their own educational experience or risk not making the transition, which makes them indignant, dispirited and resigned.

The underlying problem:

- ◆ The real problem is the program director whose conduct is self-centered and self-serving, who disregards his role as chairman of a department or division in the medical school and his obligations to medical students, and who seems to have forgotten he, too, was once a medical student seeking a residency.

As one of our junior faculty members in OB/GYN put it, "Our first priority is to get a good house staff rather than helping students get into the programs of their choice."

Specific problems:

- ◆ Programs which are not even in the Match.

Such programs feel they are not bound by any constraints; they may not be the best programs; they are often the earliest to offer the student a position; and they are the most likely to pressure the student into premature commitment.

- ◆ Programs which are partially in the Match, offering perhaps half of their PGY-1 (or PGY-whatever) positions through the Match and keeping the other positions in their back pocket for under-the-table negotiations.
- ◆ Programs which are in the Match but do not abide by the spirit and intent of the Match.
- ◆ Programs which have banded together creating separate matching programs. The "Colenbrander matches" are the best examples:

Ophthalmology (the original)
Otolaryngology

Neurology
Neurological Surgery

Dermatology and Colon & Rectal Surgery, although "Colenbrander" for a while, are now back with NRMP.

The newest match but not "Colenbrander" is the First Annual (1985) AUA Residency Matching Program for Urology (For PGY-3 positions available July, 1988).

- ✓ There is new this year the "Central Application Service for Ophthalmology" from Colenbrander. The student must send to Colenbrander a completed Colenbrander "home-made" application form, the Dean's Letter, transcript, letters of recommendation and address list. All material is then photocopied and reduced for distribution. There is, of course, a fee (\$35 for the first five addresses and \$35 for each additional five) for the service.

At least one program (West Virginia) initially announced it would accept applications only if they had been processed through Colenbrander. That program has since recanted. Apparently this is a "pilot program."

While I understand such a service represents a "convenience" for students (and therefore must be a good thing) and perhaps the idea even sprung from students, I object to it for the following reasons:

- 1) The University transcript is not longer "official" if it is duplicated and does not bear the seal of the University;
- 2) The Dean's Letter is null and void if it does bear the signature of the Dean or his designee;
- 3) There is considerable doubt in my mind whether Colenbrander has the resources to guarantee authenticity of submitted material in the manner of AMCAS, for example, where constant vigil uncovers fraud and deception.
- 4) There is doubt in my mind whether Colenbrander has the staff capable of duplicating and distributing such material in a timely manner.
- 5) The service imposes yet an earlier deadline to meet.

This year, I advised my students not to participate; Dr. Colenbrander himself phoned to learn my objections; and he said that the folders of Vanderbilt students would have to contain a letter explaining our students' non-participation.

It is interesting that Colenbrander's "Service" is trying to accomplish the reduction of duplication of effort at the same time we have been unsuccessful in gaining widespread acceptance of the AAMC's APPLICATION FOR RESIDENCY, which our students refer to as the "universal application form."

- ◆ Programs which require the student to serve in a visiting clerkship before even being considered for a residency.
- ◆ Programs which have "pre-application" in order to get an application form.
- ◆ Programs which interview on only two days in the entire fall.
- ◆ Programs which interview on only one day of the week.

Our Department of Surgery is a good example, seeing applicants only on Saturday mornings. I understand that surgeons may be operating the other five days, and maybe it is a good thing to put a ceiling on the student since there are only so many Saturdays in the fall. But, it makes scheduling difficult for students.

- ◆ Programs which establish unreasonably early deadlines for application.

I can see no justification whatever for a deadline of August 15th when interviews are scheduled after the 1st of November.

- ◆ Programs which, although no early deadlines are announced, nevertheless have a cut-off at the first, say, 100 applications for their 2 positions and will not consider any applicants after that, regardless of their qualifications.

The process of applying for internships:

- ◆ The student writes off for descriptive material and application forms;
- ◆ The application folder must be "complete" with application, Dean's Letter, transcript, all recommendations and whatever, before it is submitted to "the committee" for review (this usually takes 2 weeks);
- ◆ The "invitation to interview" is extended either in writing or by phone, and the student must then schedule the interview date, interdigitating it with any other interviews already scheduled;
- ◆ In order to qualify for reduced airfare rates, the ticket must be bought at least 30 days ahead (adding another 4 weeks to the early deadline);
- ◆ On unlimited mileage tickets, the airline often requires the passenger to return to some focal point. For example, the student flying from Seattle to San Diego may have to fly to Denver first and then transfer. It is enormously time consuming.
- ◆ The student applying to PGY-1 and PGY-2 programs (most of the Surgical subspecialties, many Radiology programs, Emergency Medicine and others) simultaneously must invest at least twice the time and effort and money and two separate rounds of applications and interviews.

Vanderbilt's Dean's Letters:

Like approximately half of the medical schools in the country, Vanderbilt's Dean's Letters are written by a single individual. He enjoys the task but earlier and earlier deadlines place undue stress on the process. Another growing problem is the total number of applications being mailed out. Last year for 100 students, we sent out 1,850 Letters and transcripts. This year, we entered into a gentleman's agreement that a reasonable number of applications for the student applying to PGY-1 programs would be 15, and for the student applying to both PGY-1 and PGY-2 programs, a reasonable total would be 25. More than that, and we charge the student for each transcript. To show you how effective that agreement has been, we have one student this year applying for Orthopedics who has, to date, requested 94 copies of his Dean's Letter and transcript.

MATCH RELIEF, INC.:

"Created by medical students for medical students" is MRI, an entrepreneurial invention introduced this summer which, for a fee of \$88, will perform some of the steps involved in NRMP application. We provide most of those for our students at no cost, such as addressing envelopes. It is designed to relieve "THE MATCH HEADACHE," but none of our students, to my knowledge, has used it.

Some possible solutions:

To combat the entropy threatening the entire transition process, DEANS should agree that there are problems, that the problems can and should be resolved, and that the problems shall be resolved by collective, concerted action on their parts.

Each DEAN should inquire of the program directors within his own institution as to their policies with respect to the transition process, realizing the solutions will not come from them individually or from their specialty associations without external force.

- ◆ Have LCME accreditation of medical schools include full participation of all its affiliated residency programs in the NRMP;
- ◆ Insist that specialty associations, if they must have separate matches, do so through the auspices of the NRMP;
- ◆ Encourage specialty associations and specialty boards to reconsider the whole training process and the undesirability of such early commitment on the medical students' part to specialty careers. Delaying selection of candidates for PGY-2 and PGY-3 positions until, at least, midway in the internship year would result in surer selection and fewer wipe-outs along the line.
- ◆ Encourage NRMP to continue reconsidering the entire process and to seek innovative solutions for implementation with the full support of the DEANS.
- ◆ Insist on the elimination of individual application forms in favor of the GRADUATE MEDICAL EDUCATION APPLICATION FOR RESIDENCY provided by the NRMP and developed by the AAMC.
- ◆ Refuse to release Dean's Letters and official university transcripts to any other than bona fide residency training programs.
- ◆ Honor the recommendation of the AAMC's Task Force on Graduate Medical Education in 1981 that no Dean's Letters and transcripts are to be released prior to October 1st, and this should include the Armed Services as well.
- ◆ Consider recommending that program directors accept residency applications only from students in medical schools approved by the LCME.
- ◆ Consider limiting the Fourth Year medical student to two clerkships in the area he intends to specialize, only one of which may be a "visiting clerkship."
- ◆ Insist that programs remove even the suggestion that a "visiting clerkship" might be pre-requisite to consideration for residency.
- ◆ Refuse to accept any "visiting students" except those from LCME approved medical schools.
- ◆ Cut back on class size.

EDITORIAL

The 'Preresidency Syndrome':
An Incipient Epidemic of Educational Disruption

A "preresidency syndrome," characterized by medical students being excessively preoccupied with gaining a position in a graduate medical education program of their choice, is spreading through the nation's medical schools. There has always been a degree of competition among students for residency positions. Competition can be healthy. It can stimulate students to excel in their studies and thus increase their knowledge and perfect their skills during medical school. However, competition can be disruptive if it diverts students from accomplishing their general professional education.

If disruption is fomented by the faculties that are responsible for students' education, faculty priorities must be questioned. Does filling the positions in residency programs take precedence over providing students time to make reasoned career decisions and the opportunity to complete the educational programs planned by their medical schools? The attitudes and behavior of many residency program directors, most of whom are medical school faculty members, suggest that the answer to this question is yes.

Fifteen years ago there were many more residency positions in all specialties than there were graduates from U.S. medical schools. Program directors competed for graduates to fill the positions in their programs. Now, with the competitive positions reversed, students are being forced to make career decisions by the end of their junior year. Further, many students are using their senior year electives to exhibit themselves at hospitals where they

hope to be selected for a residency—often because they are told that only applicants who have taken an elective in a program in that institution will be considered. As a result, these students take electives in the same specialty at several institutions and thus expend much of their senior year in the same specialty in which they will have graduate training. This disrupts the completion of a balanced, general professional education.

Medical faculties' views about these behaviors are paradoxical. On the one hand, they deplore that the senior students at their own institution are "on tour" most of the year, while they encourage students from other schools to visit them. They decry their students having to make premature decisions for residencies, but, in league with the colleagues in their specialty, they devise separate, early matching plans. They criticize the quality of deans' letters of recommendation but set such early deadlines for their receipt that students' senior-year performance cannot be included.

What is to be done? In future, even greater competition for residency positions among medical students can be expected. If faculty members, wearing their program director hats, continue their devil-take-the-hindmost pursuit of students, the preresidency syndrome will become an epidemic, and the general professional education of students will be more and more disrupted. Deans and associate deans, who have ultimate responsibility for their students' education and welfare, could, in concert, inhibit the spread of this plague by refusing to provide letters and transcripts each year

until after October 1, a date recommended by the Association of American Medical Colleges' Task Force on Graduate Medical Education in 1981. They could refuse to allow students to take more than one elective in the same specialty, or they could severely limit senior students' elective time. However, when faced with the pleadings of students who fear that their career aspirations may be irrevocably harmed by such rigid policies, most deans are forced to comply with the rules laid down by leagues of specialists who place self-interest before students' welfare.

Those who make the rules for graduate medical education must take the initiative if general professional education in medical school is to be preserved. Is there a forum where these rule-makers can come together to discuss the problems described? There are 24 autonomous, rule-making specialty boards and an equal number of rule-making residency review committees. The American Board of Medical Specialties could provide a forum for the boards, and the Accreditation Council for Graduate Medical Education could provide a forum for the residency review committees. To my knowledge, neither the boards nor the residency review committees have ever considered the recruiting practices of programs in their specialties to be of any consequence. It is time they did!

AUGUST G. SWANSON, M.D., *director, Department of Academic Affairs, Association of American Medical Colleges, Washington, D.C.*

REPORT OF THE AAMC COMMITTEE TO REVIEW THE IOM STUDY
ON THE INSTITUTIONAL STRUCTURE OF THE NIH

The final report of the Institute of Medicine study on the institutional structure of the NIH was released in November 1984. In January, the AAMC appointed an ad hoc committee to review this report. The report of the AAMC's committee, which was approved by the Executive Council in June 1985, is attached, along with a New England Journal of Medicine article written by James D. Ebert, chairman of the IOM study committee, and Michael A. Stoto, director of the IOM study staff. Members of the AAMC committee will meet with Drs. Ebert and Stoto during the AAMC annual meeting.

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AAMC REVIEW OF THE IOM REPORT

Early in 1983, the National Institutes of Health (NIH) requested the Institute of Medicine (IOM) of the National Academy of Sciences (NAS) to undertake a study of several pressing issues related to the organizational structure of that federal agency. A provision for a similar study had been included in a bill introduced into, but not passed by, the 97th Congress. The study got underway in the early spring of 1983, with the appointment of a distinguished IOM committee, and in September, the AAMC had an opportunity to submit suggestions (Attachment I) to this committee and to testify in open hearing (Attachment II) before one of its subcommittees.

The final report of the IOM committee, entitled "Responding to Health Needs and Scientific Opportunity: The Organizational Structure of the National Institutes of Health" was published on November 15, 1984. An AAMC staff document, describing the context in which the need for the study emerged and summarizing the content of the IOM report is appended (Attachment III). On November 24, 1984, the President of the AAMC appointed an ad hoc committee (Attachment IV) to review the IOM report and to develop a suitable AAMC reaction to it.

The AAMC committee was impressed by the calibre of scientific competence, intelligence and wisdom embodied in the committee constituted by the IOM for this study, and also by the diligence and thoroughness with which its members and staff went about their task. The IOM committee made itself open to all views on the matters under discussion and solicited the advice and suggestions of a very broad segment of experts who were informed about and concerned with the issues. The final report of the IOM committee was brief, incisive, to the point and generally persuasive. The ad hoc AAMC committee concurs in the major thrusts of the IOM report and in most of its recommendations; it does hold reservations about a few of the latter, however, and feels that had several other issues been addressed, the report's value would have been even greater.

Overview

In general, the IOM report endorsed the current organizational configuration of the NIH and stressed the dangers inherent in the proliferation of new institutes. Moreover, it identified no major problems or serious deficiencies at the NIH. Its recommendations were directed more at correcting external perceptions---or, more often, misimpressions---of the agency than at substantially modifying its organizational structure or modus operandi. In light of these findings and conclusions, it was somewhat puzzling and disappointing to the ad hoc AAMC committee that, since the IOM committee found so little to criticize about the NIH, its report was so restrained in its praise of this federal agency. In fact, the AAMC ad hoc committee believes that the facts of the IOM report justify high praise for NIH. We also regret that the important

issue of the growing tendency of the Congress to intervene in detail into management and program specification at the NIH was not dealt with more explicitly.

The AAMC staff paper provides an adequate description of the background for the study and accurately summarizes the content of the IOM report. Thus, our evaluation of the latter has focused on the recommendations of that document. These cluster into several groups, each with a broad theme:

- organizational and programmatic responsivity at the NIH and the DHHS
- the powers of the Director, NIH
- the internal management of selected service functions
- communication with external advisory bodies and the general public
- criteria for appointment to external advisory bodies

Responsiveness To Needs And Opportunities

The IOM committee's first six recommendations address the issue of how the NIH should make it evident that the agency is sensitive and responsive to evolving opportunities to advance the capability of medical science to cope with the diseases of mankind. The IOM committee, on the basis of a careful analysis of available data, dismissed as invalid the widely held assumption that the creation of a new institute expands federal support for research in cognate areas. It also asserted categorically that the current structure of NIH was sufficiently flexible to respond to most foreseeable research needs. However, the IOM committee was apparently impressed by the extent to which voluntary health organizations and their scientific advisors perceived the NIH as either not interested in, or not willing to accord a high priority to, the preoccupations of those organizations. The IOM committee also concluded that these organizations had persuaded the Congress that this was indeed the case. In the light of those realities, the committee urged the NIH to take steps to convince its critics that: it was committed to the solution of all tractable problems across the whole spectrum of human disease and disability; it had constituted and was actively utilizing machinery to identify and design appropriate responses to research opportunities throughout this domain; and that it was prepared to create whatever organizational apparatus, including new institutes, was appropriate to pursue these opportunities.

Processes for Evaluating Needs and Opportunities

Recommendations 1 and 2 focus on the administrative devices for maintaining congruence between the organization's structure and function in the face of progress in science.

Recommendation 1

The Director of NIH should establish an NIH-wide mechanism to (1) keep abreast of the views, concerns, and proposals of the NIH scientific and public constituencies; (2) assess their potential implications for NIH and its functioning; and (3) plan responses.

Recommendation 2

NIH should strengthen its planning efforts, particularly at the institute level and in the coordination of NIH-wide activities.

If adopted, these would institutionalize in a highly visible form an apparatus for evaluating options and designing responses, organizational and otherwise, to needs and opportunities identified either by internal analysis or by external proposals. Such a move would presumably shift the initial and primary arena in which proponents of change brought pressure to bear from the highly political climate of the Congress to the NIH, thereby regularizing the process for analysis, evaluation and response within an environment in which scientific values, criteria and standards prevail.

We strongly endorse Recommendation 1; it is to a very large extent compatible with the suggestion for a formal and visible public forum that the AAMC submitted to the IOM Committee in September 1983 (Attachment I). Recommendation 2 also is valid, provided it is recognized that, in science, planning has inherent limitations and that the road maps cannot be drawn for unknown territory.

Modes of Response to Needs and Opportunities

The evaluation of potential research needs and opportunities carried out with interaction, where appropriate, between NIH staff and advocacy groups, would from time to time identify the need for major modifications in NIH's programs. The IOM recognized that a wide variety of response options were available, including organizational change, and made several recommendations in this area. The first,

Recommendation 3

NIH should avail itself of a range of activities, short of establishing new institutes, to respond to health needs and opportunities.

urges the NIH, as a first step, to take whatever actions, short of the creation of a new institute, the conclusion of its analysis dictated.

This would be a logical and sensible consequence of accepting the first two recommendations and we support it without reservation.

Despite its strong conviction "that the current structure" of the NIH "is sufficiently flexible to respond to most needs" and "that NIH has reached a point at which there should be a presumption---to be overridden only in exceptional circumstances---against additions at the institute level, whether they are proposed to occur by fission or by transfer from outside NIH," the IOM committee felt that it must provide for the contingency of at least considering organizational modifications more fundamental than those envisioned in Recommendation 3. Thus, it advocated adoption of some formal process for considering new institutes and prescribed criteria against which such proposals should be measured, embodied in its next two recommendations.

Recommendation 4

There should be a formal process to assess proposed major organizational changes in NIH.

Recommendation 5

Criteria to Assess Proposed Organizational Changes

- a. The activity of a new institute or other organizational entity must be compatible with the research and research training mission of NIH. If a major emphasis of the proposed new entity is in regulation, in the delivery of services, or in other non-research activities, it is not appropriate for incorporation in NIH.
- b. It must be demonstrable that the research area of a new institute or other major organizational entity (defined either as a disease or health problem, or as a biomedical or behavioral process related to a health problem) is not already receiving adequate or appropriate attention.
- c. There must be reasonable prospects for scientific growth in a research area to justify the investment in a new institute or other major organizational entity.
- d. There must be reasonable prospects of sufficient funding for a new institute or other major organizational entity.
- e. A proposed change in the NIH organizational structure should, on balance, improve communication, management, priority setting, and accountability.

These recommendations are in many respects similar to the September, 1983, AAMC comments (Attachment I) to the IOM committee which expressed the view that, under its current organizational structure, the NIH was able to be responsive to the entire gamut of research opportunities and that the creation of new institutes would be counterproductive. At the same time, however, the AAMC did suggest that a comprehensive review of the appropriateness of the NIH's organizational structure be undertaken on a decennial basis, with restructuring where necessary.

We are struck by the fact that comprehensive external reviews of the structure and function of the NIH have indeed taken place at approximately decennial intervals: the Wooldridge Committee Report in 1965^{/1}; the Report

^{/1}Biomedical Science and Its Administration: A Study of the National Institutes of Health. The White House. Washington, D.C. February 1965.

of the President's Biomedical Research Panel in 1976; and this IOM Report in 1984. All except the first address the question of the creation of new institutes. The 1976 and 1984 reports were remarkably congruent on this subject. As noted earlier, the IOM asserted that there should be a presumption---to be overridden only in exceptional circumstances---against additional institutes. The President's Panel concluded:

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"The pros and cons of maintaining existing Institutes and of creating new Institutes were clearly defined in testimony before the Panel. The Panel feels that the creation of additional Institutes is not likely to make the NIH more effective; it might well make it less so. Therefore, if new programs are to be established, or existing programs strengthened, this should be accomplished through the present Institutes rather than through the creation of new ones."; and

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"The Panel also recommends that the Director, NIH, consider aggregating related Institutes into larger units, which could possibly lead to bureau structures that would decrease the span of management."

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Periodic appraisal by a body of distinguished scientists and citizens of the fitness of the prevailing organizational structure of the NIH would seem to us to be the ideal "formal process" called for in Recommendation 4. It would be a widely acceptable and highly effective mechanism to provide either: assurances to the general public, the voluntary health agencies, the Congress and the Executive Branch that the prevailing structure was appropriate; or a sound rationale for a recommended reorganization. We prefer it to any alternative we have heard suggested. Should Recommendations 4 and 5 be adopted, we would hope that the proposed criteria would be refined, extended and tightened. Moreover, we feel particularly strongly that any major proposed organizational change be required to meet all of these criteria.

Evaluation of and Response to Needs and Opportunities in the PHS

The IOM committee also identified as a perennial problem the fact that, while health research was broader than the NIH domain of biomedical research, there was a conspicuous absence of visible machinery to monitor continuously and thoughtfully organizational assignment of responsibility for medical research at the boundaries between the NIH and other PHS agencies; and to assure that the communication about and coordination of medical research between PHS agencies was being constantly scrutinized to assure effectiveness. The IOM committee's perception was that the absence of such assurance lay at the heart of recent Congressional tendencies to initiate, or to acquiesce in, organizational changes proposed by constituent groups.

To fill the void, the IOM Committee has urged the establishment of a Health Science Board to advise the Secretary on changes in the organizational

structure or function of elements in the PHS, "such as the initiation or termination of institutes of the National Institutes of Health and of other units of the Public Health Service, or of reassignment of responsibilities among institutes and units, as follows:

Recommendation 6

The Health Science Board:

- a. A Health Science Board should be established in the Department of Health and Human Services to oversee the health research organization, missions, priorities, and institutional management of the several elements of the Public Health Service: the National Institutes of Health; the Centers for Disease Control; the Food and Drug Administration; the Alcohol, Drug Abuse, and Mental Health Administration; the Health Resources and Services Administration; the National Center for Health Statistics; and the National Center for Health Services Research.
- b. On the basis of periodic review, the Health Science Board should advise the Secretary of Health and Human Services through the Assistant Secretary for Health on any change proposed in the organizational structure or function of these elements, such as the initiation or termination of institutes of the National Institutes of Health and of other units of the Public Health Service, or the reassignment of responsibilities among institutes and units.
- c. The Health Science Board should be composed of six members appointed by the Secretary of Health and Human Services from a slate nominated by the Assistant Secretary for Health after consultation with the National Academy of Sciences and the National Academy of Public Administration.
- d. Appointments should be made for a term of six years, with one-third of the board's membership replaced every two years, and the reappointment of members limited to one additional term.
- e. Members of the Health Science Board should be selected on the basis of a judicious combination of scientific experience, capacity for sound judgment, and knowledge of health policy issues and the principles of public management.
- f. The Health Science Board should elect its own chair, meet at least four times a year and additionally whenever requested by the Assistant Secretary for Health, be assigned its own staff and have a defined budget, and have the authority and resources to establish study groups or panels to assist it in its mission.

- g. The Health Science Board should report annually to the Secretary of Health and Human Services through the Assistant Secretary for Health.

The proposed Health Science Board is, as described above, assigned the task of making recommendations to the Secretary for the appropriate organizational structuring of the entire range of research activities within the Public Health Service.

The AAMC committee does not think that the creation of a Health Science Board is desirable. In the first place, we feel that the Secretary, DHHS, should be free to seek advice on such questions from whatever sources that individual deems most qualified; the very existence of a Health Science Board of the character proposed in the IOM report would limit the Secretary's freedom of choice and of action in discharging responsibilities for which that official is statutorily accountable. In the second place, the Health Science Board could very easily become politicized, at a high cost to research progress. For these reasons, we oppose this recommendation of the IOM committee.

Strengthening the Office of the Director

Recommendations 7, 8 and 9 are predicated on the IOM committee's recognition of: the importance of overall coordination of and accountability for the total NIH research program; and the divisive counterforce generated by growing institute autonomy, encouraged by narrow special interest groups and by fiscal constraints that encourage protection of the status quo. The IOM report, therefore, advocated "a strong central force to insure coordination of cross-cutting research activities, to oversee orderly long range evolution and to maintain public accountability for the NIH's overall program. The Office of the Director is the logical locus for these functions." Thus, these three recommendations were designed to strengthen the Office of the Director, an objective with which we completely concur.

Definition of Authority

The authority under which a Federal official operates is defined either specifically in statute or delegated to that official by a superior whose authority is defined in statute. The Director, NIH, has always operated under delegated authority and the IOM committee has commented on this in its next recommendation.

Recommendation 7

The Secretary of Health and Human Services should delegate to the Director of NIH the authority, direction, and control over NIH that the position does not now possess, subject to the policy direction of the Assistant Secretary for Health and to existing statutory limitations, as recommended to be modified below.

relates to these formal authorities delegated to the Director, NIH, by the Secretary, DHHS. These, the committee viewed as inadequate to really carry out the responsibilities of directing that organization. Clearly such a situation, if true, is intolerable and should be corrected at once. We would,

however, urge that, to the extent possible, the requisite authority be provided by administrative delegation rather than by statute.

Expanded Budget Authority

An important outward sign of authority is control over expenditures, and this is next addressed by the IOM Report.

Recommendation 8

The Director of NIH should have greater budgetary authority and discretion in two regards: (1) a discretionary fund, not to exceed 1.0 percent of the NIH budget, with which to seed selected areas through existing institutes in accordance with a rigorous peer review process; and (2) limited authority to transfer up to 0.5 percent of the NIH budget across institute lines in response to a public health emergency.

This is designed to strengthen the Office of the Director, NIH by providing two measures of fiscal control. The second part of this recommendation---for transfer authority---is virtually identical to an AAMC recommendation (Attachment I). The first part---the availability of an annual discretionary fund---would also serve a similar purpose and would have the additional property of taking some of the curse off the exercise of transfer authority: transfer would take funds away from one Institute (or one Institute Director or one categorical interest group) and give them to another; the discretionary authority would increment the appropriation of one or more of the Institutes.

Again, on balance, the two elements contained in IOM Recommendation 8 appear to be sound mechanisms to achieve a desirable end. Their symbolic value is particularly important. While there are not inconsequential downside risks to both proposals to enhance the Director's authority over expenditures, the possible gains appear to sufficiently outweigh the hazards as to warrant at least a 5-10 year trial, especially if the mechanisms for allocating the discretionary fund and for effecting the fund transfers can be designed to avoid certain pitfalls.

NIH Policy and Planning Council

The last of the triad of proposals to strengthen the Office of the Director focuses on the Directors Advisory Committee, a body constituted on the recommendation of the Wooldridge Committee in 1965.

Recommendation 9

NIH Policy and Planning Council:

- a. The current Director's Advisory Committee should be converted to a stronger and more independent NIH Policy and Planning Council.
- b. The Council should provide for the Director a continuous evaluation of the research mission and function of NIH and of its component institutes, with special emphasis on issues that affect NIH as a whole

or the interrelationship among the institutes. It should advise the Director in the formulation of long-term plans and in setting research priorities.

Recommendation 9 would convert the current Director's Advisory Committee into a stronger and more independent NIH Policy and Planning Council.

It seems likely that the Council's planning functions would replicate those being carried out in virtually all of the institutes, and by the Office of Program Planning and Evaluation in the Office of the Director. Constituted as proposed, as an autonomous group of advisors, with its own staff and budget, with freedom to define its own agenda, and without the responsibility and accountability characteristics that go with Federal employment, this Policy and Planning Council could, in our opinion, serve to weaken rather than strengthen the Office of the Director. We find the Director's Advisory Committee, as currently constituted, to be nearly ideal for assisting the Director without compromising his authority. The effectiveness of this advisory body could perhaps be enhanced and the members given a greater sense of involvement in the work of the Committee if a subcommittee of it were created to work with the Director and the Committee staff in the development of the agenda for each meeting.

Internal Management

The IOM committee looked carefully at the internal management of the agency and its studies yielded two recommendations:

Recommendation 10

Extramural research and intramural research (and the related support activities of each) should be grouped under two deputy NIH directors each of whom has line authority over support functions outside of individual institutes and staff responsibility for extramural and intramural research programs; the staff functions in the Director's office should be reorganized to improve span of control.

Recommendation 11

Where appropriate, support functions of individual institutes and other components should be clustered to reduce unnecessary duplication and expense.

Recommendation 10 relies heavily on a detailed review of current management practices catalogued in the Report's Appendix B by one member of the committee; the full committee strongly urged adoption of suggestions put forth with considerable diffidence by the author of the review. While these recommendations appear to us to be sound, we would defer to the judgement of the NIH management---where substantial managerial strengths reside, as recognized by the review---on these questions.

Communications with External Advisory Bodies

Presumably based on information acquired in its extensive consultations, the IOM committee felt that the interactions between the Agency and the distinguished members of its prestigious advisory apparatus could be strengthened. To this end, it made two recommendations.

Recommendation 12

Each institute should provide its National Advisory Council members with full and easily understandable information on its entire portfolio of currently funded grants and grant proposals; institute directors should more uniformly involve their advisory councils in broad program and policy issues.

Recommendation 13

The NIH Director should assume overall responsibility for informing members of each institute's Board of Scientific Counselors of that institute's response to its recommendations about intramural research.

These are directed at enhancing the function of two types of external advisory bodies---one, for extramural research, the National Advisory Councils, the other, for intramural research, the Boards of Scientific Counselors---that play critical quality control roles in the programs of the agency. The skillful selection and utilization of advisors has been the hallmark of successful and productive social institutions in both the private and public sector---Boards of Trustees in Academe, Boards of Directors in the business community. The major force of these two recommendations is for the NIH staff to keep advisory bodies better informed, and thus to enable those groups to carry out their responsibilities more effectively. We fully endorse that objective and would concur in all sound mechanisms to effect its realization.

Public Information

The IOM committee concluded that the American public---the major patron of U.S. science in general and NIH's in particular---has not been made sufficiently aware of how the NIH has discharged its stewardship of the public funds entrusted to it. Its next recommendation:

Recommendation 14

The role and staffing of the Office of Communications should be strengthened. The Director of NIH should establish an Advisory Panel on Public Information, to assist the office in improving the breadth of distribution of current publications, and in employing additional media.

is aimed at redressing this situation.

Again, we agree wholeheartedly with the goal---to make the NIH and its achievements better known to the citizens of the Nation. The recommendation of the IOM committee could contribute significantly. Other devices to attain

this same end may be even more important. Higher levels of government have tended to limit, for a variety of reasons, the ability of the agency to tell its story. It may be that grantee institutions will have to do more to keep the public aware of the importance of the NIH to the nation's biomedical research effort.

Selection of Advisors

The final recommendation of the IOM committee:

Recommendation 15

Quality should continue to be the overriding consideration in selecting all NIH advisory group members--scientific, clinical, and lay. The expertise of the advisory groups must be of the highest possible quality if they are effectively to fulfill their statutory responsibilities and to have credibility within the scientific community, with Congress, and with the public at large. Further, every effort should be made to reduce the levels of review and to expedite the selection process, so that advisory groups can always function at full strength.

relates to the criteria that should determine the selection of appointees for the NIH advisory apparatus. In unequivocal terms, the Committee insists that competence and integrity of the highest order should characterize appointments---scientific, clinical and lay---and that selection based on other considerations can only serve to compromise the quality of the national endeavor.

This recommendation is one that will command universal and enthusiastic assent throughout the scientific community. The meteoric ascendancy of U.S. biomedical science in the last four decades can be attributed, in our opinion, to the willingness of the principal patron, the Federal government, to subscribe to a system of resource allocation under which the selection of research proposals for funding was carried out through a process of national competition, judged first by the scientific peers of the competitors and then by scientists, clinicians and laity expert in and sensitive to the health needs and desires of the citizenry. The NIH, early on, adopted, and has subsequently sought to maintain, the practice of nominating for its advisory bodies only individuals with outstanding qualifications and of unchallengeable integrity. Higher appointing authority usually endorses NIH recommendations. That policy has yielded spectacular dividends. It should be preserved inviolate.

Omissions

While the IOM committee's report is thorough and offers recommendations that are, with the exceptions noted, sound, we were disappointed that two matters were not addressed more directly: increasing Congressional "activism" in reauthorizing the NIH, and the general appreciation of the NIH within the scientific community of the USA and the world.

Government Control vs. Scientific Freedom

In our view, the imminence of proliferation of new national institutes under the umbrella of the NIH was simply one especially pressing reason to examine a more profound and portentous phenomenon that has been growing for more than a decade: the ever increasing detail and specificity of proposed, as well as enacted, Congressional directives to the NIH.

The mutually satisfactory relationship that characterized the first twenty five to thirty years of generous Federal support to biomedical science in the United States, principally through the NIH, quickly disarmed the skeptics who, in the late 1940's, held serious reservations about the propriety of government becoming the patron of science. But it is worth remembering that in the immediate post World War II period, when the Nation stood in awe of contributions of science to the successful prosecution of the recently concluded global conflict, and when strong public pressures existed to continue the mobilization of science for public purpose through the creation of a National Science Foundation (NSF), many eminent leaders in the scientific community held and expressed serious doubts about such a national policy. Their concerns stemmed from fear that an unacceptable degree of government control, determined more by political rather than scientific considerations, would attend government support and that such control would compromise the freedom to select the most promising approaches to problems so essential for scientific progress. The scientific community's preoccupation with the essentiality of a high degree of autonomy, even under a system of publicly financed research, was reflected in the early formulation of the NSF's charter. The first bill passed by the Congress provoked a veto on the grounds that expenditure of public funds required greater public accountability than was embodied in the proposal sent the President by the Congress.

While there is inherent and inescapable tension between Congress's responsibility to hold science accountable for its responsiveness to public mandates and the imperative that science needs freedom to function effectively, the fears and forebodings of these distinguished scientists were soon dissipated by the satisfactory balance struck for many years between scientific freedom and government control. This issue remained latent for decades. But in our opinion this tension, at least in the case of the biomedical sciences, began to surface in the early 1970's. The Congressional restraint that generally prevailed from the late 1940's to the early 1970's has noticeably waned, while the intensity of detailed Congressional intervention has grown.

We are convinced that the effectiveness of the biological and medical sciences in solving the Nation's health problems will be profoundly compromised if government, through its Executive or Legislative Branches, imposes a degree of control that distorts the inherent imperatives of science. We are also convinced that the last decade has witnessed a significant shift in this balance towards government control. At issue is not whether government has the right or duty to intervene as it sees fit. Indisputably it does. The crucial question is how much intervention is compatible with the public policy objective of improving health and conquering disease through scientific research. The IOM committee, by a broad reading of its mandate, could have surfaced this critically important issue and explored its nature and ramifications. We regret that it declined to seize this opportunity.

The Overall Assessment of the NIH

Our other disappointment in the IOM committee's report is that it failed to convey the phenomenal esteem in which the NIH is held by scientists throughout the United States and the whole world. Many of the members of this AAMC committee can remember the state of biomedical science and of the research enterprise in that domain before the modern NIH came on the scene. All of us have been involved with the NIH throughout most of our professional careers---as members of its scientific or administrative staff, as grant supported investigators, as participants in its advisory apparatus, or as faculty and administrative officials in grantee institutions. In the competition for NIH funds, we have each won a few and lost a few. But the overarching reality is that during our working lives the NIH has continuously and steadily exerted a remarkably and powerfully beneficent influence.

For almost four decades the biological and medical sciences have flourished in this country as nowhere else and as have no other fields of science, under the patronage of a government agency less like government than any other public enterprise ever encountered by its clients. Under a series of brilliantly conceived and skillfully executed procedures, it has exerted quiet leadership and delicate direction on the course of science, without improper interference or compromise of excellence, while at the same time generally satisfying the need of Congress for accountability. It has allocated the generous amounts of public funds entrusted to it with perceptiveness and sensitivity to the emerging opportunities for both scientific progress and health improvement. It has aided talented students to fulfill their aspirations for careers in the medical sciences. It has shown continuous concern for, and supported reasonably effectively, both the institutions in which research takes place and the infrastructure for that activity. It has built a superb intramural research program whose "graduates" have leavened the research programs of every major research university of this Nation. What other federal agency has an alumni association whose periodic reunions are as enriching as college, university, or medical school reunions?

The NIH is viewed by the American medical science community as an extraordinary modern phenomenon. It has been remarkably successful for four decades with little change in its basic operating principles and procedures. In good times and bad times it has performed with a very high degree of professionalism to improve the health of the Nation and blunt the baleful impact of disease, disability and premature death through fostering the most meritorious and relevant research. Throughout the last 40 years, in which it spent almost \$53 billion of public funds, NIH has been virtually untouched by a breath of scandal or charged with the slightest malfeasance. Is it any wonder that the scientific community feels a proprietary and protective interest in this agency, and springs to its defense at the merest provocation when major changes in its organization or functions are proposed?

While it is probable that the members of the IOM committee also subscribe to this view of the NIH, their report stints in its recognition of this agency's sterling virtues. Encomiums may be unnecessary for the scientific community. But the important audiences for this report are federal legislative and executive officials and the general public. Those audiences understand the NIH only incompletely and sorely need to hear authoritatively of what a superb institution the NIH is and of the potential peril to the health of the

Nation that will come from inadequately informed tinkering with its organization or functions.

Conclusion

The AAMC committee concurs in the basic objectives sought by the IOM committee in its recommendations. The NIH should take such measures as are necessary, short of creating new institutes, to demonstrate to the scientific community, to narrow special interest groups, to the Congress, to the Executive and to the general public its deep interest in and its openness to opportunities across the entire spectrum of problems that threaten human health. In our view, the formal administrative process for evaluating proposals for new institutes should take the form of an approximately decennial study similar to those of the Wooldridge Committee, the President's Panel or the current IOM Committee; for any such study committee, subsequently organized to carry out this task, we urge that a more detailed, refined and discriminatory set of criteria be developed and that any proposal, to pass muster, be required to meet all of these criteria. We also agree with the IOM committee's assessments: that the NIH, as presently organized is sufficiently flexible to respond to most foreseeable needs; and that there should be a presumption---to be overridden only in exceptional circumstances---against additional institutes. We have reservations about the proposed Health Science Board, since its existence would seem to compromise the freedom of the Secretary, DHHS, to seek advice from whatever source(s) were appropriate on matters over which that Board would have cognizance. We concur in the objective of strengthening the Office of the Director, NIH. The recommendations to give that official more extensive and specific delegations of authority as well as expanded budgetary authority and discretion are reasonable, provided steps are taken to minimize some of the risks involved in the latter devices. However, the degree of autonomy provided to the proposed Policy and Planning Council could weaken rather than strengthen the Office of the Director and so we view the gains in creating it not worth the risk. The management improvements with respect to National Advisory Councils and Boards of Scientific Councilors are unquestionably desirable. We would prefer to view the recommendations on internal management only as suggestions for the NIH to consider; the organization has managed its affairs creditably for a long time and is in the best position to evaluate the worth of these proposals. That the programs and accomplishments of the NIH deserve to be better known and understood by the American public is certainly true but we are not clear as to what obstacles must be overcome to attain the desired result. Finally, we laud the IOM committee's reminder that the appointment of advisors of the highest possible competence and integrity is the sine qua non of a biomedical research program of excellence.

AD HOC MCAT REVIEW COMMITTEE

At its June 1985 meeting, the Executive Council established an *Ad Hoc* Committee to review the Association's MCAT program. The committee is charged to explore how the MCAT examination is used in the selection of medical students and to make recommendations to the Executive Council on possible improvements in the program. The committee members are:

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

Richard S. Ross, M.D.
Dean
Johns Hopkins University
School of Medicine

Nathan Kase, M.D.
Dean
Mount Sinai School of Medicine

Walter F. Leavell, M.D.
Dean
Meharry Medical College
School of Medicine

Douglas E. Kelly, Ph.D.
Chairman
Department of Anatomy
and Cell Biology
University of Southern California
School of Medicine

Daniel D. Federman, M.D.
Dean, Students & Alumni
Harvard Medical School

Frederic D. Burg, M.D.
Associate Dean for Academic Programs
University of Pennsylvania
School of Medicine

Billy B. Rankin
Director, Admissions
Baylor College of Medicine

Andrew G. Wallace, M.D.
Vice Chancellor for Health Affairs
and Chief Executive Officer, Duke
University Hospitals
Duke University School of Medicine

John Dejong
Medical Student
University of Kansas School of Medicine

William H. Luginbuhl, M.D.
Dean
University of Vermont
College of Medicine

REVIEW OF THE AAMC MCAT PROGRAM

The Medical College Admission Test (MCAT), its use by medical schools in their selection process and the effects of this use on undergraduates and undergraduate institutions have been the subject of substantial interest and attention over the recent period. So called "truth-in-testing" legislation has attacked the very premise of standardized testing, coaching courses have exploited the anxieties of eager students, and multiple choice examinations have been accused of eroding the capacity for problem solving. Admissions tests are viewed as distorting curricula of the educational segment which precedes them and of contributing to student behavior which is neither scholarly nor socially desirable. The MCAT itself has been stolen, litigated over, legislated against, repudiated by one member institution and tagged by others as such an important source of revenue for the AAMC as to create conflict of interest which precludes effective oversight by the AAMC, its staff and governing bodies. This state of affairs suggests the appropriateness of an Executive Council consideration of the issues associated with the MCAT program.

Background

The current MCAT Examination was first offered in 1977 after an extensive, nearly six year planning process which engaged the active participation of pre-professional advisors, medical school faculty, practicing physicians, medical students, and admissions officers, with a particular emphasis on including the perspectives of women and minorities in the process. The result is an exam almost unique among admissions tests in its prior specification of the competencies identified as relevant to the study and practice of the field and the design of the instrument to assess those particular competencies. Thus, no longer is there a general science portion of the exam. Rather, the test assesses achievement and problem-solving skills in 54 specific topics in chemistry, physics, and biology judged by the extensive panel of medical faculty and students to be most relevant to the study and practice of medicine. In order to avoid stimulating an undue emphasis on science at the pre-baccalaureate level, the topics are examined only to the extent that they are covered in the introductory level courses at the vast majority of colleges supplying candidates for the study of medicine. Similarly, the general knowledge, verbal and mathematic components of the predecessor examination were abandoned in favor of assessments of thinking skills applied to information presented in prose and quantitative formats. Identified as desirable, but never implemented after an examination of its feasibility, was a component designed to assess non-cognitive personal characteristics. In response to suggestions emanating from the Council of Deans and endorsed by the Executive Council, the Association is now engaged in an extensive pilot project designed to evaluate the utility of an essay component to the examination.

Immediately upon offering the new examination the AAMC enlisted the cooperation of member schools to assess its utility in the admissions process, its impact on the selection of women and minorities and its validity in terms of the correspondence between MCAT scores and performance in medical school as measured by grades in the basic sciences courses and performance on the NBME Part I examination. Few have been surprised that there is a high positive correlation between MCAT scores and performance in the first two years and an inverse relationship between scores and academic mortality and morbidity. Criticism has been focused on the relative paucity of research on the relationship between MCAT scores and performance in the clinical studies or as a physician. This, notwithstanding the non-specificity of available criterion measures and the significant correlation between scores and Part II of the NBME examination.

Research has also been conducted and replicated on the impact of commercial coaching courses on both first-time and repeating examinees. The results are consistent in showing a general score improvement for all repeaters and score differential favoring coached examinees *which is limited to the four science subtests*. The score differences average approximately *one-half* of a scale score point in each science area of assessment. (In the mid-range, 7-9, changes in scores of a *full* point increase the probability of acceptance 10 percentage points.) Additional findings were that coaching effects on science performance are trivial for examinees with low skills scores (1-6), for examinees with very low GPA's, and for examinees from very selective undergraduate colleges and/or with very high GPA's. This leads to the relatively unremarkable conclusions that: 1) science is teachable to (or learnable by) students with reasonably well developed fundamental skills; 2) learning science is difficult for those who have reached this stage of their career without well developed skills; and 3) scientifically sophisticated students will not appreciably improve an already high performance by means of a short term effort. These conclusions tend to be reinforced by more recent studies which demonstrate that the inverse relationship between MCAT scores and academic morbidity is the *same* for both coached and uncoached students. In summary, the improvement in performance by coached students does not appear to be short term, artifactual, or undeserved; rather it seems to be a reflection of their capacity, desire and effort to learn and the achievement of this objective. This is not to deny that there may be undesirable consequences of the large and growing resort of applicants to commercial coaching.

Legislative activity of the "truth-in-testing" variety has been mostly quiescent since the AAMC successfully invoked the protection of the Federal copyright laws in New York. That case has not yet gone to trial, but may be expected to do so within the next year unless a legislative resolution is achieved--an outcome not now foreseeable.

Current Issues

It has been asserted that the current use of the MCAT is frequently inconsistent with the GPEP report's exhortation that "premedical" students should aspire to a "broad" education prior to entry into medical school.

- Is the MCAT so focused on science as to frustrate a liberal education? Is this inherent to the examination or a result of incorrect use?
- Does the MCAT have an unavoidable role in stimulating the "premed" syndrome? Would changes in its use or design affect this situation? What impact would an essay component have? Changes in course prerequisites?
- What role, if any, does a standardized test properly play in medical school admissions? Is there a need for more than letters, grades and interviews to assess candidates? How are grades from unknown or less prestigious institutions to be assessed?
- Are coaching courses a problem? Are there ways to alleviate the adverse effects of coaching courses?
- Is the Association in a conflict of interest situation created by an undue dependence on revenue from the examination? (See attached report to the State of California)

PRELIMINARY RESULTS FROM THE MCAT ESSAY PILOT PROJECT

Introduction

The Association of American Medical Colleges (AAMC) is investigating the desirability and feasibility of including an essay as part of the Medical College Admission Test (MCAT). This endeavor, entitled the MCAT Essay Pilot Project, calls for the administration of an essay topic on a trial basis with each of the Spring and Fall MCAT administrations in 1985 and 1986. The overall objectives of the MCAT Essay Pilot Project are to plan, develop, implement, and evaluate an essay written by MCAT examinees under standard conditions and in response to a topic developed with specific criteria.

The MCAT essay was administered for the first time in the Spring of 1985. The Spring essay topic was designed to provide examinees with an opportunity to demonstrate skill in: 1) developing a central idea, 2) synthesizing concepts and ideas, 3) separating relevant from irrelevant information, 4) developing alternative hypotheses, 5) presenting ideas cohesively and logically, and 6) writing clearly, observing the accepted practices of grammar, syntax, punctuation, and spelling consistent with timed, first draft composition.

Under the guidance of an Ad Hoc Advisory Committee to the MCAT Essay Pilot Project, an evaluation program was developed to determine if the essay should become a part of the MCAT testing program on a permanent basis. The evaluation plan is divided into four phases. Within each phase, there are two primary questions:

Phase 1 -- What is the nature of the information provided by an essay? What are the performance characteristics of various examinee groups?

Phase 2 -- What is the impact of the essay on the selection process? Is the information provided by the essay unique and useful to student selection decisions?

Phase 3 -- What effect does an essay on the MCAT have on the attitudes and course selection of undergraduate students? Does the presence of an essay on the MCAT have any impact on the undergraduate curriculum or the types of applicants?

Phase 4 -- What are the costs associated with the development, administration, and distribution of an MCAT essay? What different methods (and their costs) are available for the evaluation and distribution of essays?

The data reported below provide preliminary information on Phase 1 and part of Phase 2 of the evaluation plan. The analyses will be discussed in detail at the Annual Meeting session

entitled, "MCAT Essay Pilot Project: Preliminary Data", on Sunday evening from 7:30 to 9:30 at Lincoln East.

Sample Composition

Twenty-two thousand examinees were tested in the Spring of 1985. A sample of 3000 examinees was selected to represent the demographic and academic characteristics of the population of Spring Saturday examinees. Essays for these 3000 examinees were scored by 20 experienced readers from the California university system. The data in Tables 1 and 2 show that the study sample was representative of the Spring 1985 examinee population and generalization from sample data to the population of Spring examinees is warranted.

Table 1

Demographic Characteristics of Spring Examinees and Essay Sample

		Spring 1985 Examinees	Essay Sample
Sex	Male	63.3 ^a	63.0
	Female	36.7	37.0
Race	Black	6.0	7.0
	White	77.5	76.2
	Asian	10.2	10.0
	Hispanic	3.9	4.4
Language Dominance	ESL	1.8	2.1
	Native English Speaker	98.2	97.9
College Year	Freshman	.6	.3
	Sophomore	4.8	2.4
	Junior	52.2	54.0
	Senior	19.3	20.1
	Graduate + Not Enrolled	19.3 3.8	19.3 3.9
Home Community	Rural ^b	17.9	16.4
	Urban	82.1	83.6
Multiple Testings	First-time Examinee	81.8	81.1
	Repeat Examinee	18.2	18.9

^aPercent

^bIncludes examinees from towns < 10,000

Table 2

MCAT Scores for Spring Examinees and Essay Sample

	<u>Spring 1985 Examinees</u>	<u>Essay Sample</u>
Biology	8.5 ^a 2.5 ^b	8.5 2.5
Chemistry	8.4 2.5	8.4 2.5
Physics	8.4 2.6	8.4 2.6
Science Problems	8.3 2.5	8.3 2.5
Skills Analyses: Reading	8.1 2.4	8.0 2.4
Skills Analyses: Quantitative	7.9 2.5	7.8 2.5

^aMean^bStandard DeviationResearch Questions

The following research questions were addressed using sample data:

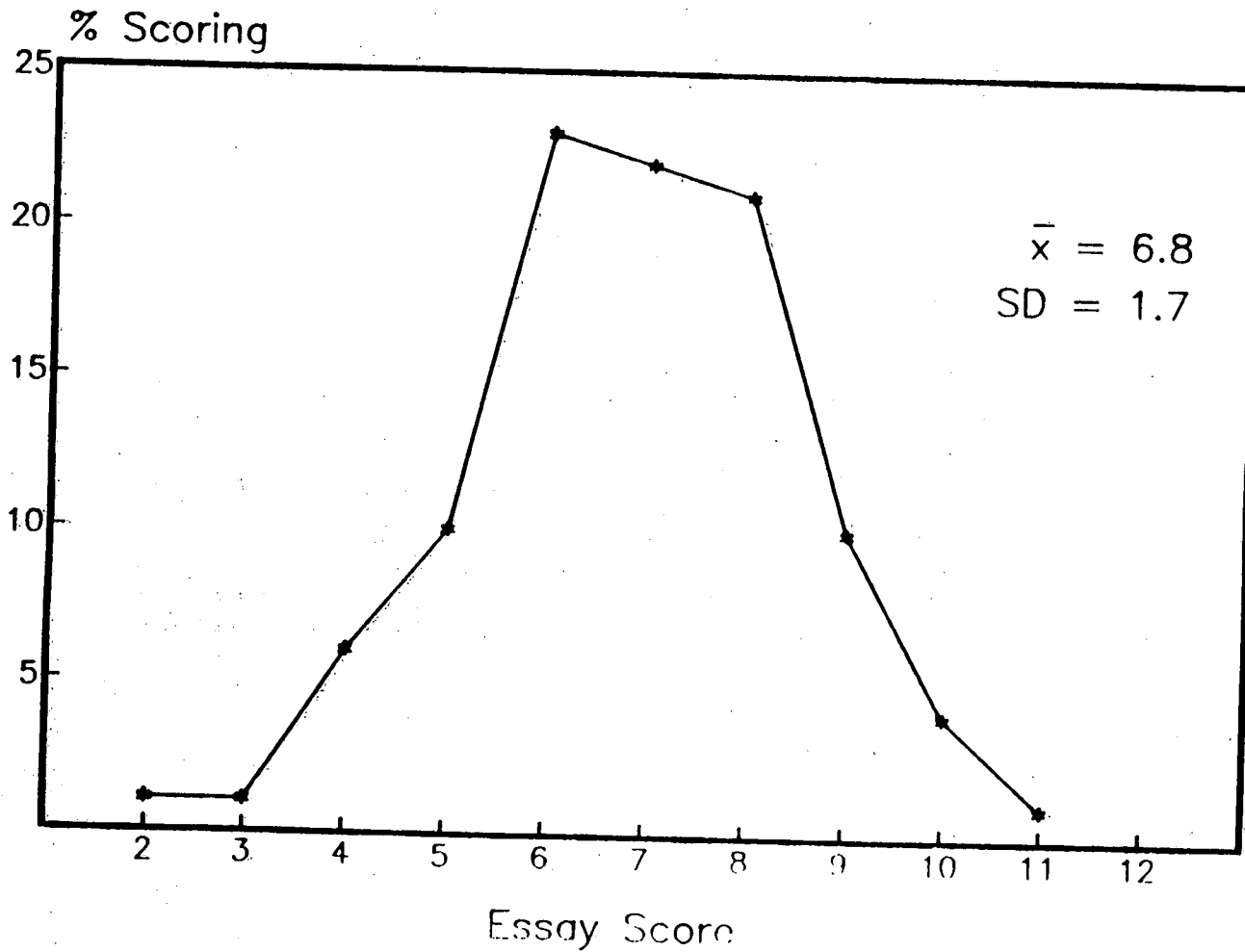
1. What are the performance characteristics of the total sample and of sample groups differentiated by sex, home community, race, and language dominance?
2. What are the relationships between essay scores and such demographic/academic characteristics as age, years of post-secondary education, and college selectivity?
3. What are the relationships between essay performance and scores on the science and skills analysis tests?

Essay Results for the Scored Sample

Essay results for the 3000 examinees in the scored sample appear in Figure 1. The score scale for the essay ranged from 2 to 12. The mean essay score for the sample was 6.8. The standard deviation was 1.7. The data were normally distributed and all score points were represented.

Figure I

Essay Sample Results



Results for the Essay Sample Groups

Essay means and standard deviations were calculated separately for students grouped by sex, race, rural/urban status, and language dominance. Group data are presented in Table 3. Group differences were negligible for male/female and rural/urban examines. Group differences did appear, however, for race and language dominance groups. Figures 2 and 3 show test score distributions for blacks, whites, Hispanics, and Asians. Essay distributions are plotted for the four groups in Figure 2 and Biology results appear in Figure 3.

The distributions in Figures 2 and 3 help demonstrate that even though there were mean score differences between the race groups on the essay, these differences were smaller than those observed on the science and skills analysis tests. Average group differences on the essay were about 1/2 a standard deviation. Group differences were closer to a whole standard deviation on the science and skills analysis tests.

Table 3
Essay Results for the Sample Groups

		<u>Mean Score</u>	<u>Standard Deviation</u>
Sex	Males	6.8	1.7
	Females	7.0	1.7
Home Community	Rural	6.9	1.6
	Urban	6.8	1.7
Race	Black	5.9	1.6
	White	7.1	1.6
	Hispanic	6.5	1.7
	Asian	6.6	1.9
Language Dominance	ESL ^a	3.7	1.6
	Native English Speaker	6.9	1.7

^aIncludes only Commonwealth Puerto Ricans.

When average essay scores were examined across groups for students at the same Skills Analysis: Reading levels, blacks scored an average of 1/4 point below the mean essay scores for examinees at the same reading levels. Whites scored 1/10 point above the mean essay scores for test-takers at the same reading levels. Hispanics and Asians scored 1/10 point below the average

Figure 2
Essay Results by Racial/Ethnic Status

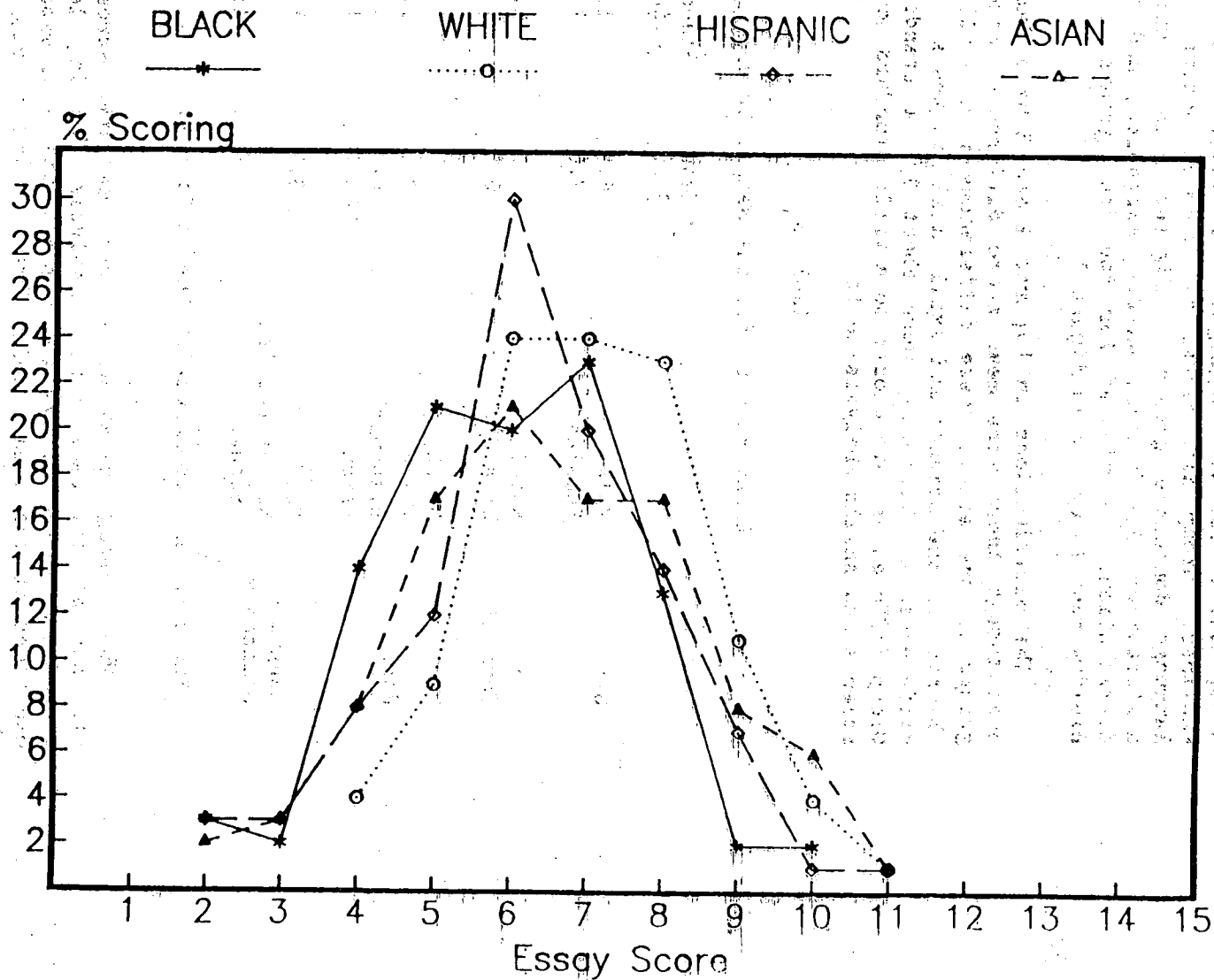
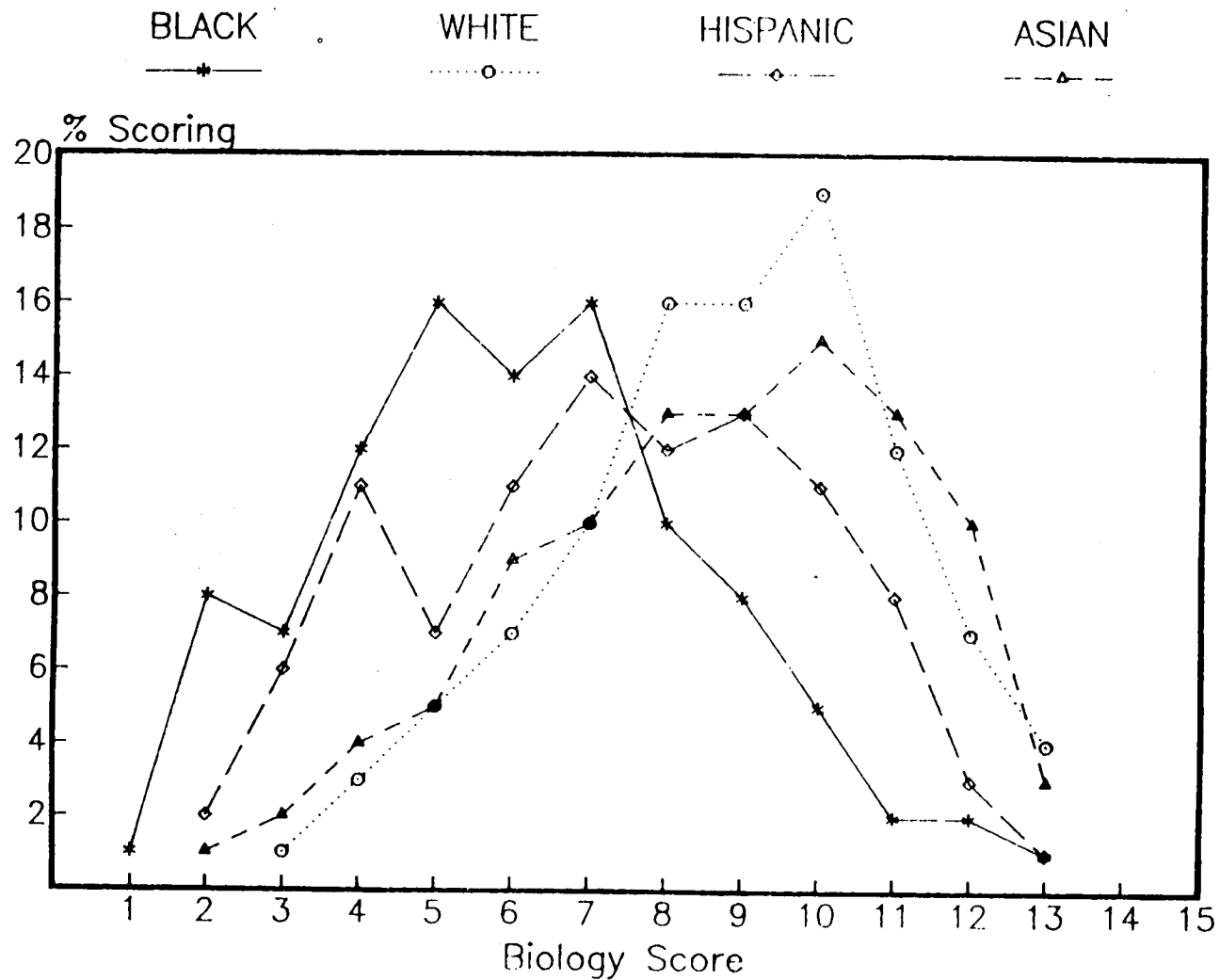


Figure 3
Biology Results by Racial/Ethnic Status



essay scores controlling for reading level. Hence, even though there were differences in essay performance for examinees of different racial groups, these differences were largely related to basic skills or reading level differences. That is, the writing exercise, itself, did not uncover differences between groups when data were examined for test-takers at the same reading score levels.

Data for Commonwealth Puerto Ricans, however, were less encouraging. These students scored 2 points below the mean essay score for examinees at the same reading levels. Factors other than reading level differences may have contributed to lower performance for these examinees. A special data collection is planned on Commonwealth Puerto Ricans for the Fall to investigate these differences.

Relation between Essay Scores and Demographic/Academic Characteristics

Means and standard deviations for essay data at levels of selected demographic/academic variables appear in Tables 4-9. These data show no relationship between essay performance and 1) age, 2) years of post-secondary education, and 3) number of English semester hours. There was a positive relationship between essay scores and examinees' self-ratings in writing and reading. That is, examinees proved to be good judges of their writing ability. There was also a positive relationship between essay performance and college selectivity. Students from selective undergraduate institutions received high essay scores, and those from less selective schools received lower scores.

Table 4

Mean Essay Scores by Age Group

<u>Age</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
19	7.2	1.9	118
20	7.1	1.6	824
21	6.9	1.6	801
22	6.5	1.6	290
23	6.6	1.8	190
24	6.7	1.8	129
25	6.6	2.0	90

Table 5

Mean Essay Scores by Years of Postsecondary Education

<u>Years of Postsecondary Education</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
2	7.2	1.6	68
3	7.0	1.6	1498
4	6.6	1.8	671
5	6.6	1.8	492
6	7.1	1.8	58

Table 6

Mean Essay Score by Number of English Semester Hours

<u>Course Hours in English</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
0- 4	7.0	1.6	384
5- 8	6.8	1.6	1103
9-16	6.8	1.8	852
17-24	7.0	1.7	62
24+	6.7	2.3	96

Table 7

Mean Essay Scores by Self-Rating in Writing

<u>Rating</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
Below Average	6.6	2.1	45
Average	6.2	1.6	551
Above Average	6.8	1.6	1020
Top 10%	7.3	1.6	771
Top 1%	7.6	1.8	154

Table 8

Mean Essay Scores by Self-Rating in Reading

<u>Rating</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
Below Average	6.8	2.0	36
Average	6.3	1.6	497
Above Average	6.7	1.7	1066
Top 10%	7.2	1.6	741
Top 1%	7.5	1.7	196

Table 9

Mean Essay Scores by College Selectivity

<u>College Selectivity</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>n</u>
Mean SAT \leq 892	6.3	1.7	396
893 \leq Mean Sat \leq 1036	6.7	1.7	1027
1037 \leq Mean SAT \leq 1181	7.0	1.6	773
Mean SAT \geq 1182	7.5	1.6	494

Relation between the Essay and Science and Skills Tests for First-Time Examinees

Correlations between the essay and other tests are shown in Table 10. The correlations between the essay and science tests ranged from .27 to .29. The correlations between the essay and skills tests were higher; Skills Analysis: Reading had the highest correlation with the essay, $r = .43$. These intercorrelations were lower, however, than those observed among the science and skills analysis tests themselves; observed intercorrelations for these tests ranged from .55 to .88. This says that the essay was measuring a skill or skills that were different from those assessed in the current six-test battery.

Table 10

Correlations Between the Essay and Science and Skills Tests

	<u>Essay</u>
Biology	.29
Chemistry	.28
Physics	.27
Science Problems	.29
Skills Analysis: Reading	.43
Skills Analysis: Quantitative	.38

When essay scores were predicted from data for the six MCAT tests, the overall or combined correlation was .45. This means that 20% ($.45^2$) of the variance in the essay score distribution was common to or overlapped with variance on the other tests.

Using this index of overlap and using data about the reliability of the essay and the science and skills analysis tests, an estimate of the amount of unique reliable variance in the essay distribution was derived. The resulting "uniqueness" estimate was 49%. This index says that 49% of the variance in the essay score distribution was reliable and related to abilities or traits that were unexamined by the other tests. These results do not necessarily say that the validity of selection decisions will increase by 49% when essay data are introduced. Data are not available on the relationship between the unique skills measured by the essay and performance in medical school. Performance data will be collected as the project progresses. If evidence for a positive relationship between essay scores and performance in school are obtained, an increase in the predictive validity of the battery will be realized.

Future Research

Validity data will be collected for a small number of students currently enrolled in medical school. The impact of the essay on the selection process will be investigated by schools participating in 1) simulated admissions decision-making exercises using the essay, 2) retrospective selection activities using the essay and 3) active use of the essay in admissions decision-making for Fall 1987. Research on the impact of the essay on the attitudes, course selection, curriculum, and application patterns of undergraduate students is currently being designed. Cost data on the development, administration and distribution of the essay will become available as the project progresses.

DISTINGUISHED SERVICE MEMBER

The Council of Academic Societies has proposed that Robert L. Hill, Ph.D., former chairman of the Council of Academic Societies, be elected to Distinguished Service Membership in the AAMC.

1986 CAS SPRING MEETING

The CAS Spring meeting will be held at the Sheraton Washington in Washington, D.C. on March 26 and 27, 1986. The plenary session on Wednesday, March 26 will include a consideration of the implications for the faculty of the changing environment in academic health centers, including a discussion of the effects of changes in faculty practice on the academic mission of the faculty. In addition, there will be a discussion of a number of the issues that are currently before the AAMC Research Policy Committee.

The CAS business meeting will be held from 9 am until noon on Thursday morning, March 27.

October 28, 1985 (Monday)
Washington Hilton, Washington, D.C.

The AAMC Clinical Evaluation Program Sessions

Session I

4:30 - 5:30 p.m.

Ballroom Center

The Outcome of the AAMC Clinical Evaluation Program

Dr. Tonesk will describe the outcome of the Clinical Evaluation Program. The discussants will comment from their diverse perspectives: Dr. Federman as a member of the clinical faculty and the Dean's office; Dr. Stemmler as a Dean whose school has been involved in the study; and Dr. Rabkin as a teaching hospital director.

Daniel D. Federman, M.D., Chairman
Dean for Students and Alumni
Harvard Medical School

Xenia Tonesk, Ph.D.
Director, Clinical Evaluation Program
AAMC

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

Mitchell T. Rabkin, M.D.
President
Beth Israel Hospital, Boston

Session II

5:30 - 6:30 p.m.

Ballroom Center

Reflections on Participating in the Self-Study of Clinical Evaluation Systems

Victor R. Neufeld, M.D.
Associate Dean for Education
McMaster University

Opportunities for Discussion with Representatives from the Pilot Schools

Schools represented include: UCLA, UCSF, Jefferson, LSU-New Orleans, McMaster, Oklahoma, Pennsylvania, U. of Washington, Uniformed Services. Each school will have a station at which a representative will be available to answer questions and discuss the process and the results of self-study.

FUTURE MEETING DATES

AAMC Annual Meeting Dates

- 1986 - October 25 - 30 (New Orleans, Louisiana)
CAS meetings tentatively scheduled for October 26 and 27
- 1987 - November 7 - 12 (Washington, D.C.)
CAS meetings tentatively scheduled for November 8 and 9
- 1988 - November 12 - 17 (Chicago, Illinois)
CAS meetings tentatively scheduled for November 13 and 14

CAS Spring Meeting Dates

- 1986 - March 26-27 Sheraton Hotel (Washington, D.C.)
- 1987 - March (Washington, D.C.)

CAS Administrative Board Meeting Dates (1986)

- January 22-23
- April 9-10
- June 18-19
- September 10-11