

## PHYSICIAN PAYMENT REVIEW COMMISSION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) mandated the formation of a Physician Payment Review Commission. This 11-member Commission will make recommendations to the Congress by March 1 of each year regarding adjustments to the reasonable charge levels for certain physician services (essentially those under Medicare) and changes in the methods for determining the rates of payments for such services. The Commission also will advise and make recommendations to the Secretary of Health and Human Services regarding a relative value scale, which the Secretary is required to develop. Members of the Commission, who are appointed by the Director of the Office of Technology Assessment, include:

Philip R. Lee, M.D., director of the Institute for Health Policy Studies, School of Medicine, UC-San Francisco (chairman)

Oliver H. Beahrs, M.D., professor of surgery emeritus, Mayo Medical School

Robert N. Butler, M.D., professor and chairman of geriatrics and adult development, Mount Sinai School of Medicine

Karen Davis, Ph.D., chairman of health policy and management, Johns Hopkins School of Hygiene and Public Health

John Eisenberg, M.D., M.B.A., associate professor of general medicine, University of Pennsylvania School of Medicine

Jack Guildroy, member of the National Legislative Council of the American Association of Retired Persons

Mark C. Hornbrook, Ph.D., senior investigator and senior economist, Center for Health Research, Kaiser Permanente, Portland, Oregon

Carol Ann Lockhart, M.S., R.N., executive director, Greater Phoenix Affordable Health Care Foundation, Phoenix, Arizona

Walter Mc Nerney, professor of hospital and health services management, J. L. Kellogg Graduate School of Management, Northwestern University

Thomas R. Reardon, M.D., private practitioner, Portland, Oregon

Uwe E. Reinhardt, Ph.D., professor of economics and public affairs, Princeton University

## COUNCIL ON GRADUATE MEDICAL EDUCATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended the Public Health Service Act to create a Council on Graduate Medical Education. Prior to July 1, 1988, and every 3 years thereafter, this Council will make recommendations to the Secretary of Health and Human Services, the Committee on Labor and Human Resources and Committee on Finance in the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means in the House. These recommendations will relate to:

- 1) the supply and distribution of physicians;
- 2) current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties;
- 3) issues relation to foreign medical graduates;
- 4) appropriate federal policies with respect to the above, including policies concerning changes in the financing of undergraduate and graduate medical education programs, and changes in the types of medical education training in graduate medical education programs;
- 5) appropriate efforts by hospitals, medical schools, schools of osteopathy, and accrediting bodies with respect to the above, including efforts for changes in undergraduate and graduate medical education programs; and
- 6) deficiencies in existing databases concerning the supply and distribution of, and post-graduate training programs for, physicians in the United States, and steps that should be taken to eliminate those deficiencies.

The issues to be considered by this Council are unquestionably among the most significant to confront academic medicine, and the Association will continue to track federal efforts to address these questions. Although Public Law 99-272 instructed the Secretary of Health and Human Services to appoint the members of the Council by June 7, 1986, the Department unexplainedly has not yet done so.

1987 CAS SPRING MEETING

March 18-20, 1987

The Woodlands Inn  
The Woodlands, Texas

Wednesday, March 18

5:00 - 7:00 p.m. Registration and Reception

7:00 - 9:00 p.m. Dinner and Keynote Address

Thursday, March 19

7:45 - 8:30 a.m. Breakfast

8:30 a.m. - 12:30 p.m. Plenary Session

12:30 - 2:00 p.m. Luncheon

7:00 - 9:00 p.m. Dinner  
Speaker: Robert G. Petersdorf, M.D.  
President, AAMC

Friday, March 20

7:45 - 8:30 a.m. Breakfast

8:30 a.m. - Noon Business Meeting

The Woodlands Inn is 27 miles from downtown Houston, on the shores of Lake Harrison. American Airlines has been selected as the official carrier for the CAS Spring Meeting, and will offer 35-40% discounts off their regular coach airfares.



**association of american  
medical colleges**

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

**SUNDAY, OCTOBER 26, 1986**

**SPECIAL GENERAL SESSION**

**2:00 - 4:30 P.M.**

**VERSAILLES ROOM**

**CAS RECEPTION**

**5:00 - 7:00 P.M.**

**MAGNOLIA ROOM**

**MONDAY, OCTOBER 27, 1986**

**CAS BUSINESS MEETING**

**1:30 - 5:00 P.M.**

**MARLBOROUGH A & B**

**NEW ORLEANS HILTON HOTEL**

**NEW ORLEANS, LOUISIANA**

## FUTURE MEETINGS

### Administrative Board/Executive Council

January 21-22, 1987	Washington Hilton
April 15-16, 1987	Washington Hilton
June 17-18, 1987	Washington Hilton
September 9-10, 1987	Washington Hilton

### CAS Spring Meeting

March 18-20, 1987	The Woodlands Inn Houston, Texas
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### AAMC Annual Meeting

November 7-12, 1987	Washington, D. C.
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# CAS

COUNCIL OF ACADEMIC SOCIETIES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
1 Dupont Circle, N.W.  
Washington, D.C. 20036

COUNCIL OF ACADEMIC SOCIETIES  
1986 ANNUAL MEETING  
OCTOBER 26-27, 1986  
NEW ORLEANS HILTON  
NEW ORLEANS, LOUISIANA

The schedule for the 1986 Annual Meeting of the Council of Academic Societies is as follows:

SUNDAY, OCTOBER 26

2:00 - 4:30 p.m.  
Versailles Room

**SPECIAL GENERAL SESSION**

"Graduate Medical Education and the  
Transition from Medical School to Resi-  
dency"

**Moderator:**

Edward J. Stemmler, M.D.  
Chairman-Elect, AAMC  
Executive Vice President and Dean  
University of Pennsylvania School of  
Medicine

Institutional Responsibility

Spencer Foreman, M.D.  
Chairman, AAMC ad hoc Committee on Grad-  
uate Medical Education and the Transition  
from Medical School to Residency  
President, Montefiore Medical Center

**Reactors:**

Frank A. Riddick, M.D.  
AMA Member of ACGME  
Ochsner Clinic

C. Rollins Hanlon, M.D.  
Director (emeritus), American College of  
Surgeons

Problems at the Transition

Commentator:

Joseph S. Gonnella, M.D.  
Dean and Vice President  
Jefferson Medical College

Reactors:

Robert B. King, M.D.  
Chairman-Elect, ABMS  
Chairman, Department of Neurosurgery  
SUNY Upstate Medical Center at Syracuse

Ture W. Schoultz, M.D.

Chairman, AAMC Group on Student Affairs  
Associate Dean and Director, Student  
Affairs  
University of Arkansas College of  
Medicine

5:00 - 7:00 p.m.  
Magnolia Room

CAS RECEPTION

MONDAY, OCTOBER 27

1:30 - 5:00 p.m.  
Marlborough A&B

CAS BUSINESS MEETING

5:00 - 6:30 p.m.  
Prince of Wales Room

SPECIAL SESSION

The Aging of Medical School Faculty:  
Implications for Institutional Renewal  
and Productivity

Moderator:

Eleanor Shore, M.D.

Faculty Age Distributions and Research  
Productivity  
Paul Jolly, Ph.D.

Faculty Renewal in the University of  
California System  
Paul Friedman, M.D.

Increasing Flexibility in Academic  
Staffing: Lessons from Higher Education  
Kenneth Mortimer, Ph.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF ACADEMIC SOCIETIES

ANNUAL BUSINESS MEETING

Monday, October 27, 1986

1:30 p.m. - 5:00 p.m.

Marlborough A & B

New Orleans Hilton

AGENDA

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MINUTES  
1986 SPRING MEETING  
OF THE  
COUNCIL OF ACADEMIC SOCIETIES

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

CURRENT ISSUES IN FACULTY PRACTICE

The 1986 Spring Meeting of the Council of Academic Societies began with two plenary sessions. The first session was devoted to a panel discussion of faculty practice from the various perspectives of the dean, the hospital administrator, and the faculty. Members of the panel were Edward J. Stemmler, M.D., dean, University of Pennsylvania School of Medicine; Thomas Q. Morris, M.D., president, Presbyterian Hospital of New York; Wilton Bunch, M.D., Ph.D., dean for medical affairs, University of Chicago School of Medicine; and Alan K. Pierce, M.D., chairman of the faculty practice plan, UT-Southwestern Medical School.

Dr. Stemmler, who is chairman of the AAMC ad hoc Committee on Faculty Practice, described the Committee's efforts to identify the various problems faced by academic medical centers with respect to the changing practice environment. The Committee was aided by an Association survey of deans, chairmen of practice plans, and hospital executives. As a result of its initial meeting, the Committee requested that the AAMC Management Education Program organize a series of regional workshops to provide deans, faculty, and hospital directors an opportunity to discuss the various practice issues that they face. Stemmler also noted that the Association is attempting to obtain funding for a national invitational workshop on faculty practice.

Stemmler outlined four major points with respect to faculty practice at many institutions. First, medical education is unique in that it is the only form of professional education that believes it must have an influence on the service unit in which its graduates will function. Second, the emergence of third party payment mechanisms, particularly Medicare and Medicaid, has contributed to the heavy dependence that institutions have placed on practice income. Third, the inflow of funds from these third party carriers has led to the creation of a "full-time" faculty that the institutions could not support in the absence of such funds. Finally, the expansion of this full-time faculty has required some compromises in the traditional academic criteria for appointment, promotions, and tenure.

Stemmler said that there has been a step-wise change in the academic medical center environment that is being driven by two forces: the surplus of physicians, and efforts at health service cost containment. He added that the major push for cost containment comes from the private sector. As a result of this changing environment, the education and research missions of the medical center are being seriously threatened.

According to Stemmler, there are three questions to be considered. Should the service institutions continue to be operated as part of the educational enterprise? How can the internal organization of academic institutions, which are heavily populated by specialists, be reconciled with a service structure that emphasizes non-specialists? And what will happen when the clinical practice burden on the faculty becomes so heavy that they cannot teach or do research?

Dr. Morris explained that faculty practice plans generate the financial resources to support a wide range of individuals and programs in addition to patient care. They support residents and fellows as well as other professional personnel. They also support equipment and clinical research. In addition, practice plans provide a cohesive, broad-based group with which the hospital can negotiate and discuss issues. Practice plans have the potential to deliver care expeditiously and efficiently. And some departmentally based practice plans (e.g., anesthesiology, radiology, and pathology) can reduce hospital expenditures and generate a great deal of salary support.

There are, however, some disruptive aspects that can result from practice plans. Dr. Morris noted that practice plans tend to exclude the voluntary staff at many institutions. These individuals suffer economic hardships, are excluded from certain referral patterns, denied access to certain units and beds, and have limited access to various diagnostic specialty units. With greater competition and economic demands, warned Dr. Morris, the practice plan can become an adversarial force for the hospital.

Academic medical centers, according to Dr. Morris, are passing out of a golden age and are being faced with a serious, real competition that they have not had in the past. The pressure to adjust is coming not only from the government, but also from business, which is finding that it must get its health care costs under control. Whether because of the physician surplus or changes in delivery systems, academic medical centers are being surrounded by for-profit institutions that have demonstrated that they can deliver quality health care for less. He added that, with the exception of a few "flagship" institutions, the for-profits have very little interest in education or clinical research.

Dr. Morris concluded with several suggestions for future reflection on these issues. The clinician teacher should be recognized and encouraged. Institutions should emphasize recruiting clinician teachers and providing them with attractive career opportunities. He noted that academic tenure is often less important than clinical tenure. Dr. Morris also stressed the important role that voluntary faculty have in many institutions and urged that they be encouraged.

Graduate medical education must be reexamined, particularly with respect to the distribution between general training programs in medicine, pediatrics, and obstetrics/gynecology versus specialty programs. Dr. Morris said that there is little doubt that the number of residents in specialty programs will have to be decreased. As a result, the institutions will have to look to new systems for providing health care, both within the hospital as well as in ambulatory settings, to supplement the traditional resident staff.

Finally, Dr. Morris said that medical centers should examine how they develop hospital networks. These have been based historically on teaching and

research, with patient care as a secondary element. Future relationships between institutions may emphasize patient care.

Dr. Bunch reviewed the perceptions of two groups of faculty that he interviewed regarding their practice plans. The first group participated in a full-time, straight salary plan; the second in a clinically driven incentive plan. Dr. Bunch noted that there was a strong sense of self-selection on the part of the faculty toward the different types of plans; that is, individual faculty members were drawn to a particular institution in part because of the characteristics of the practice plan at that institution. He added that the majority of faculty seemed satisfied with their particular type of plan. Those in the full salary system stressed that their plan allowed teaching and research, while those in the incentive plan liked the reward for clinical practice and felt that their plan gave their institution more flexibility.

Dr. Bunch drew several conclusions from his talks with faculty. First, that medical schools would be well advised to introduce change in faculty practice plans slowly. Ideally, such change would occur as a variation of a fixed plan. He explained that the given practice plan of an institution represents the university's value system to the faculty. Whether or not the institutional values really shift, changes in the practice plan are perceived as shifts in institutional values. Thus, administrative changes in practice plans should be introduced with a sensitivity to the ways in which the faculty will perceive these shifts.

Second, an institution cannot solve its problems by simply changing its practice plan. The value structure within the institution may go too deep to be altered by an administrative revolution. However, with creativity, a given practice plan can be shifted subtly to begin to resemble another type of plan. The perception of the faculty when subtle adjustments are made is a sense of continuity in the institution's traditions and mission. Such subtle adjustments can protect the overarching purposes of the institution, retaining the implied and generally accepted values of the original plan.

Third, and perhaps most importantly, leadership is much more important than any given practice plan. Strong leadership can bring about a successful balance within any given plan. An effective chairman can make the necessary adjustments to alter a plan and to introduce variations as long as he successfully manages the faculty and their interests. Dr. Bunch explained that it is equally important to articulate the common goals and purposes to make the necessary changes acceptable.

Dr. Pierce noted that the concerns identified by the AAMC survey appeared to be universal for faculty everywhere. The burden of the practice plan often falls disproportionately to the junior faculty; that is, the junior faculty are expected to take the major role in the clinical care of patients. He noted three major issues: the apportionment of faculty time, concerns about the recruitment of faculty, and the rewards for that apportionment.

According to Dr. Pierce, the faculty note that many administrators (including department chairmen) frequently do not recognize the major time commitment necessary for patient care. This problem is compounded when working with referral patients. The faculty also feel that the administration does not understand that faculty that are clinically active are being called upon to spend increasing amounts of time in non-reimbursable patient activities, such as follow-up with family members and chart work, but which is nevertheless

clinical work. In addition to clinical time, there are increasing commitments for quality assurance, risk management, peer review activities, and other institutional committees.

Dr. Pierce stated that most faculty in many institutions are recruited as if the "triple threat" physician-scientist-teacher still exists. Faculty are recruited on the basis of their promise as independent investigators, yet their time is consumed in the activities listed above. The result is many faculty believe they have not been given a chance for success in the academic system. They simply do not have the necessary time to read, to think, and to do research if they are responsible for patient care, which must always come first.

As a result, many of these faculty must give up on academic tenure. Although there has been much discussion of the "second track," many young faculty believe that it is a second class track in academic institutions. The palpable reward by the institution in terms of tenure is not awarded to clinicians, but to those who have preserved their time for research by not undertaking patient care. Most medical schools have no such equivalent recognition for individuals in clinical practice. As a result, young faculty see a two-tiered system between those lauded by the university and those vital to the university but not recognized.

Dr. Pierce stated that the practice that young faculty generate frequently is not a rewarding one. The departmental structure at most medical schools precludes a true group practice environment. Teaching may also be less than rewarding for these faculty as practice is shifted to an outpatient environment, where teaching is more difficult.

In conclusion, Dr. Pierce noted that the solutions to these problems are difficult, but that an underlying theme is for institutions to develop new systems of recognition -- both monetary and non-monetary -- and to make those in clinical practice feel that they are part of the university.

#### FEDERAL RESEARCH POLICY

The second plenary was devoted to a discussion of the draft report of the AAMC ad hoc Committee on Federal Research Policy. Dr. Cohen described the origins and development of this report, which was scheduled for consideration by the Executive Council on April 10. He explained that this was a broad position paper on biomedical and behavioral sciences research that was in response to various congressional and departmental initiatives in the area of federal research policy. The Committee, which was chaired by Edward N. Brandt, Jr., M.D., was formed in June 1985, and charged to review Association policy in six major categories:

- 1) goals of the federal research effort
- 2) research manpower and training
- 3) research infrastructure
- 4) research awards system
- 5) federal funding for research
- 6) formulation of science policy

Various faculty members of the Committee discussed the conclusions and recommendations contained within the report.

David Skinner, M.D., chairman of surgery, University of Chicago Pritzker School of Medicine, explained the Committee's recommendations for the scale and scope of the federal investment in biomedical and behavioral sciences research. He noted that during times of economic constraint, when the nation needs to cut back its medical care expenditures, is when the investment in research should be sustained or increased. This is because this research will result ultimately in more efficient and less costly health care. Thus, the Committee recommends that the appropriations for the NIH and ADAMHA research and research training should be increased by 10 percent per year for the next 5 years to maintain stable purchasing power in the face of the increased cost of research because of advanced technology and by an additional 5 percent to 10 percent per year for 5 years to take advantage of currently unmet scientific opportunity. The Committee also recommended a one-time infusion of additional funds to ADAMHA to restore purchasing power to the level of the mid-1970s.

Recommendations related to the priorities for the federal research effort during times of constrained funding were discussed by Thomas Q. Morris, M.D., president of Presbyterian Hospital of New York. The Committee felt that the present system of federally supported biomedical and behavioral sciences research had several underlying strengths that should be preserved during periods of fiscal stringency.

The Committee recommended continued emphasis on support for fundamental biological and clinical research, which is the cornerstone for efforts to develop new knowledge to advance health care. The Committee stressed that the highest funding priority should be for investigator-initiated research. This type of research, which is conducted in a number of settings, including multi-investigator and multidisciplinary, is the most productive in terms of new information and research opportunities and provides maximum creativity and flexibility. The federal system of biomedical and behavioral sciences research should remain predominantly extramural and academically based. Dr. Morris noted that this diverse collection of institutions is capable of undertaking research problems of varying degrees of scale and complexity. At the same time, the Committee acknowledged the crucial and vital contributions in research, training, and leadership made by the intramural programs at the NIH and ADAMHA.

Robert Fellows, M.D., Ph.D., professor of physiology and biophysics at the University of Iowa College of Medicine, reviewed the Committee's recommendations related to the scientific merit review system. He explained that as resources become constrained, scientific merit review comes under increasing pressures, both from without and within the scientific community. Direct allocation of resources by the Congress, known as "scientific porkbarrel," has become more prevalent. The Committee reaffirmed the Association's long-standing support for peer review, stating that it is the appropriate primary basis for the allocation of federal funds. The Committee also recommended that priorities of funding to meet national goals should be determined by the individual institute advisory councils, and funding decisions within these priority areas should be based on scientific merit as determined by study section review. At the same time, the Committee recognized the potential for problems within the peer review system and endorsed the efforts of the NIH and ADAMHA to maintain the quality of the review process. The Committee suggested that there be a periodic formal evaluation of the mechanisms for scientific merit review of grant applications.

Dr. Cohen presented the Committee's recommendations on indirect costs. The Committee endorsed the concept that the federal government should bear the full cost of the research it supports. Thus, appropriately audited research costs assigned by convention or choice to the indirect costs category are a legitimate component of the total cost of research, and their payment is as critical to research productivity as the payment of direct costs. The Committee recommended that all segments of the research community should join together in a concerted effort to agree on the components and accounting of indirect costs. The Committee also called for efforts to streamline current bureaucratic requirements that add unnecessary administrative burdens to research institutions and divert scarce research funds.

Peter Whybrow, M.D., chairman of psychiatry at the University of Pennsylvania School of Medicine, discussed the section on facilities. He said that there has been no direct competitive federal grant program for construction for over a decade. No one knows the actual state of research facilities in the biologic sciences. Thus, one of the first recommendations by the Committee in this area was that the federal government should assume the responsibility for an ongoing assessment of the condition of research facilities at universities and medical centers, and that this data should be the basis for policy decisions and program planning to ensure that the capacity of the nation's biomedical research enterprise is sustained. The Committee decided that the implementation of facilities revitalization should be through the competitive grants mechanism. The Committee also recognized that there are methods for institutions to recover private investment through the indirect costs mechanism. Thus a two-pronged approach was recommended, which included programs of direct merit reviewed capital grants and opportunities for phased recovery of capital investments from non-federal sources.

The final area discussed was research training, which was presented by Benjamin Schwartz, M.D., Ph.D., professor of medicine at Washington University School of Medicine. The Committee recognized the need to maintain a reservoir of highly trained research investigators in the biomedical and behavioral sciences. The Committee endorsed continued federal support via heterogeneous mechanisms, particularly for postdoctoral trainees, who rely heavily on federal funds. Career development awards were acknowledged as appropriate mechanisms to support the transition of young trainees to fully qualified, independent investigators. The Committee endorsed the practice of giving the majority of NRSA grants to institutions to support the optimal research training milieu.

The Committee also focused on two areas of future concern. First is the decline in the number of individuals preparing for careers in biomedical research. It was felt that the NAS should monitor this trend, and studies should be undertaken to identify reversible causes for this decline. Second, the Committee was concerned that there are fewer physician investigators in the biomedical sciences. The Committee strongly endorsed specific initiatives by the NIH to increase the length and quality of research training opportunities available for clinical scientists.

## MARCH 27 BUSINESS MEETING

### I. CALL TO ORDER

The 1986 Spring Business Meeting of the Council of Academic Societies was called to order at 9:00 am. David H. Cohen, Ph.D., chairman of the CAS, presided. A total of 57 individuals, representing 47 of the 82 member societies, were present.

### II. APPROVAL OF THE MINUTES

The minutes of the October 27-28, 1985 Annual Meeting of the Council of Academic Societies were approved as submitted.

### III. ISSUES OF REPRESENTATION FOR THE COUNCIL OF ACADEMIC SOCIETIES

Dr. Cohen explained that the continued increase in faculty societies seeking membership in the CAS has led to questions regarding the criteria for Council membership, representation within the Council, and selection of the CAS Administrative Board. In response to several recent inquiries, the Board undertook an extensive discussion of these issues at its January 1985 meeting.

The Board reaffirmed the current policy of relatively open admission to the Council, with review on an application by application basis. With regard to representation within the Council, Dr. Cohen explained that the Board felt that each society should have two representatives and that the position of Public Affairs Representative should be eliminated. The Board encouraged societies to appoint their representatives for terms of 4 to 8 years to enhance continuity; however, this was only a suggestion as the Board believed it was inappropriate to dictate a specific duration of term to any society. Dr. Cohen noted that the Rules and Regulations of the CAS should be amended to allow societies discretion in the term of appointment for their representatives. The Board also recommended that each society should have only one vote, rather than the present one representative/one vote policy. After considerable discussion by the Council, Dr. Cohen said that the Board would reconsider this specific recommendation.

The Board strongly reaffirmed that the qualifications of the individuals selected for the Administrative Board should have a much higher priority than the disciplines or societies represented by these individuals. To increase the flexibility in selecting Board members, the Administrative Board recommended that the current custom of maintaining a 6:6 ratio between basic scientists and clinicians should be modified to a scenario where at least 4 members are basic scientists, 4 are clinicians, and 4 are selected without regard to discipline. Finally, Dr. Cohen reminded the Council that the nomination process for the Administrative Board is open and encouraged individuals to contact members of the CAS Nominating Committee with their suggestions.

#### IV. DRAFT REPORT OF THE AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

Louis Sherwood, M.D., one of the CAS representatives on the AAMC Committee on Financing Graduate Medical Education, described the conclusions contained within the Committee's final draft report. This report was scheduled to be presented to the Executive Council on April 10. He explained that this Committee was formed in response to various proposals from congressional committees and others, such as the Social Security Advisory Council, which had raised serious questions regarding the current mechanisms for funding graduate medical education.

The Committee had discarded the idea of establishing a separate mechanism or "superfund" for graduate medical education, fearing the possible implications of funding residency training totally by a mechanism subject to political control. At the same time, the Committee was concerned about the increasing economic pressures on teaching hospitals, which challenged them to remain competitive with non-teaching hospitals and at the same time pay the expense of graduate medical education.

Thus, the Committee recommended that teaching hospital revenues from patient care should continue to be the principal source of support for graduate medical education, but that modifications be made in what they are expected to fund. All health care payers, including Medicare, should continue to provide their appropriate share of support for graduate medical education. In addition to patient care providers, other sources currently providing funds for health care training need to continue to participate in funding residency training or, in fact, may be called upon to provide greater support in the future.

The Committee considered the responsibilities of institutions and medical educators for the quality of programs provided in the public trust. The Committee recommended that the medical education community should continue to monitor the quality of its residency training and provide assurances that graduates of its residency programs are adequately prepared for practice. The institutions receiving funding should recognize their obligations to train the types of physicians needed by society. These institutions also must recognize their obligation to operate the training programs in a cost-effective manner.

The next issue considered was the types of trainees and programs to be funded through hospital revenues. The Committee recommended that funding for graduate medical education should be limited to graduates of medical schools approved by the Liaison Committee on Medical Education or the American Osteopathic Association. Only residents in programs approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association's Committee on Medical Education should be funded. The ACGME and the AOA should accredit programs solely on the basis of whether the programs meet the educational criteria established. Funded training opportunities in residency programs should be sufficient to enable all graduates of LCME or AOA approved schools of medicine to enroll in an ACGME or AOA approved residency program.

Once the principle that everyone who graduates from medical school should have the opportunity for residency training had been accepted, the next real issue was the length of training for which societal support might be expected. The Committee recommended that residents in approved training programs should be

funded largely by payments to teaching hospitals by patient care payers at least through the number of years required to achieve initial board eligibility in their chosen discipline. One additional year of funding beyond initial board eligibility should be provided from teaching hospital revenues for fellows in accredited training programs to the extent that the hospital funded such training in 1984. An individual should be supported from patient care payer's payments to teaching hospitals for a maximum of 6 years of graduate medical education. Furthermore, the Committee stated that beyond the first year of fellowship training, clinical training for fellows should increasingly be supported by government or corporate grants, physician practice income, private philanthropy, and other sources.

The Committee also recommended that a coordinated, nationwide, private sector effort should be made to collect and disseminate information on the supply of physicians by specialty. The Committee called for funding for graduate medical education to support residents and institutions in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the trainees. Finally, the Committee recommended that the Veterans Administration and the Department of Defense should continue their support of residency training, particularly providing support for the education of physicians to meet the special service needs of veterans and armed forces personnel. Other providers of service that are not typically among those receiving direct payment for services rendered to individual patients should continue their support of graduate medical education, particularly for those specialties needed for their unique patient populations.

#### V. ALTERNATE FISCAL 1987 BUDGET PROPOSAL OF THE AD HOC GROUP ON MEDICAL RESEARCH FUNDING

Gary Hunninghake, M.D., a member of the CAS Administrative Board, presented the budget proposal prepared by the Ad Hoc Group on Medical Research Funding for the NIH and ADAMHA for fiscal 1987. He explained that this proposal, which takes the form of single figure recommendations for the NIH and ADAMHA, was developed by a steering committee, of which the AAMC is a member.

The Ad Hoc Group has requested \$6.079 billion for the NIH in fiscal 1987, which would provide for a current services budget, including full funding of 6,100 competing research project grants. This request includes an additional \$86 million above current services, which would permit full funding of the NAS recommended number of research trainees (11,075), add funds for General Clinical Research and other centers, add funds for primate centers and animal facilities, and permit a modest growth in Research Career Awards. This additional money would also cover the cost of moving nursing research to the NIH this year in the newly mandated Center for Nursing Research.

For ADAMHA, the Ad Hoc Group has requested \$465 million, which is 14.8 percent over current services. This would fund 691 competing research project grants, support the NAS recommended number of research trainees (1,200), permit growth in the Research Scientist Development Awards, support the renovation of research labs and the purchase of new equipment, and allow the intramural program to increase its full-time equivalent positions and purchase equipment.

Dr. Hunninghake urged all CAS societies to endorse the Ad Hoc Group's proposal. Last year, over 150 organizations signed-on to the proposal, which greatly increased its impact on the congressional appropriations committees.

## VI. FISCAL 1987 BUDGET RESOLUTION

Elizabeth M. Short, M.D., director of the AAMC Division of Biomedical Research, explained the effect of the Gramm-Rudman-Hollings deficit reduction legislation on the federal budget process. She noted that the budget committees in both the House and the Senate must develop budget resolutions that meet the Gramm-Rudman-Hollings deficit targets. The appropriations committees must follow the funding ceilings provided in these resolutions closely. This means that the budget committees must now become the targets of the aggressive lobbying that was once reserved for the appropriations committees.

Dr. Short said that both the House and Senate budget committees had voted down the president's proposal for fiscal 1987 and were attempting to develop alternatives. The Senate Budget Committee has completed this process, and the committee's proposal will be considered by the entire Senate sometime after the Easter recess. She explained that the Senate Budget committee proposal, which was originally proposed by Senators Domenici (R-NM) and Chiles (D-FL), would essentially freeze the budget function for health (550) at the fiscal 1986 level, after sequestration. While this is an increase over the president's proposal, it is clearly insufficient to take full advantage of current research opportunities. Dr. Short stressed the need for CAS representatives and societies to contact their senators to urge their support for additional funding for medical research and health care. She added that Senators Weicker (R-CT) and Andrews (R-ND) may introduce an amendment on the floor of the Senate during the debate of the budget resolution to add more funds for research and health care. So far, the House Budget Committee has not begun consideration of its resolution.

## VII. TAX REFORM OF 1986 -- FACULTY CONCERNS (see attached Update)

Ernst Jaffe, M.D., a member of the CAS Administrative Board, described the implications of the various tax reform proposals for faculty, particularly their pension plans. He noted that the bill passed by the House in December 1985 would severely limit both contributions and withdrawals from pension plans. Withdrawals would be possible only with termination of employment, at age 59, or for disability or death. Furthermore, withdrawals after termination of employment prior to age 59 would be subject to a non-deductible excise tax equal to 15 percent of the amount withdrawn in addition to the income tax due on the money.

Employee contributions to 403(b) annuities under the House proposal would be limited to the lesser of \$7,000 or the percent limitation under current law. Contributions to a tax deferred annuity would reduce the employee's allowable contribution to an IRA by an equal amount. This means that if an individual contributed \$2,000 to a tax deferred annuity, he or she would not be able to contribute to an IRA. The House proposal would also limit total annual contributions to 403(b) plans to \$25,000. In addition, the House plan would tax pension funds such as TIAA-CREF.

Meanwhile, the Senate Finance Committee has been considering a proposal developed by its chairman, Senator Robert Packwood (R-OR). This proposal, which reportedly has the support of the president, is more favorable to pension plans such as those contributed to by faculty. The Packwood plan would not tax TIAA-CREF. It would not apply a number of the restrictive rules to 403(b) pension plans that are currently applied to the profit making

sector. The Packwood proposal would maintain the current \$30,000 limit on total annual contributions to defined plans. This bill, however, does not address fully all faculty concerns. For example, it does not eliminate the \$7,000 cap on salary reduction agreements that was proposed by the House.

Dr. Jaffe urged CAS societies and representatives to support the Packwood proposal. He encouraged them to write to the Senator to thank him for his efforts and to contact other Senators to urge them to support this bill or other more liberal provisions, first in committee, and then when the bill is considered by the full Senate. Dr. Jaffe reminded the Council that even if the Packwood proposal is passed by the Senate, it must be conferenced with the House version. Thus, the battle over tax reform is far from over.

#### VIII. ADMINISTRATION PROPOSALS FOR PART B REIMBURSEMENT OF PHYSICIANS AND PART A REIMBURSEMENT OF HOUSE STAFF TEACHING COSTS

Dr. Short described the current developments with respect to two administration proposals for regulations to limit Medicare payments to physicians. The first, which has already been published in draft form in the Federal Register of February 16, would establish "special reasonable charge limits" on payments for services (including supplies and equipment) reimbursed under Medicare Part B. This regulation is purported to address instances where the standard method for determining reasonable charges results in payments that may not be reasonable. It is, in fact, a very open-ended initiative in which the Health Care Financing Administration is going to look at physician fees, starting with certain expensive procedures. The comment period for this proposal has been extended until April 4, and the final rule is scheduled for July 1986.

The second proposed regulation, which is still in draft form within the Department of Health and Human Services, would reduce payments for graduate medical education. Dr. Short noted that the passage and signing of the budget reconciliation package will mark the first recognition in law of Medicare payments for graduate medical education. This regulation is expected to be published by the end of March, to be implemented in July. This regulation would retain only the stipends and benefits for housestaff as part of the direct passthrough. All other costs, including payment for supervising faculty, would be cut. Dr. Short said that a sample of cost reports from 66 teaching hospitals available to the AMC indicated that implementation of this regulation might result in some institutions losing half of the funds currently received for graduate medical education.

Dr. Short urged all CAS representatives and member societies to contact HCFA, the Department of Health and Human Services, and members of Congress to protest these regulations. She said that members of the AAMC Executive Committee were scheduled to meet with HHS Secretary Bowen on April 9, and that these regulations and the entire issue of financing graduate medical education were on the agenda for that meeting.

#### IX. AMICUS BRIEF FOR APPEAL IN ANIMAL "STANDING" CASE

Joe Coulter, Ph.D., a member of the CAS Administrative Board, asked CAS representatives to sign their respective societies on to an amicus curiae brief that is being prepared in response to the Primate Protection League et al. appeal to gain legal standing to take possession of the primates involved in the Taub case. The AAMC, the National Association for Biomedical Research, and a number of other professional societies have joined together to submit an

amicus brief, which will provide the court with information about the issues being discussed and the ramifications for biomedical research of providing standing to animal groups. The current case is a significant legal test case. If standing is granted to animal groups, the number of similar suits to obtain possession of laboratory animals could be substantial. Dr. Short added that signing on to the brief does not obligate a society to an cost, although contributions are being accepted to help defray the legal expenses associated with preparation of the brief. The final date to sign on to the brief was extended until mid-April.

#### X. APHIS FUNDING

Dr. Short explained that the AAMC was attempting to enlist support for additional funding for the Department of Agriculture's Animal and Plant Health Inspection Service (APHIS), which is responsible for the animal inspections and other regulations mandated by the Animal Welfare Act. She noted that the administration is trying to cut funds for APHIS, while both the scientific community and the animal rights groups are seeking additional funding. She urged CAS representatives to sign their societies on to a letter which had been jointly written by Frankie Trull of NABR and Christine Stevens, who is a leading animal activist.

#### XI. CURRENT PROPOSALS ON REIMBURSEMENT OF INDIRECT COSTS FOR RESEARCH

Dr. Cohen reviewed the latest attempt by the White House Office of Management and Budget (OMB) to revise Circular A-21, which governs the reimbursement of indirect costs associated with federally supported research. This proposal, which appeared in the Federal Register of February 12, 1986, would cap the administrative component of indirect costs -- general administration, departmental administration, sponsored projects administration, and student administration and services -- at 26 percent of the modified total direct costs (MTDC) as of April 1, 1986. This cap would be lowered to 20 percent of MTDC on April 1, 1987. Dr. Cohen noted that federal agencies had the option to delay the cap for one year, but HHS declined. The savings from this reduction would revert to the Treasury and would not be recovered as direct costs. This revision was published with only a 30 day comment period, which precluded any serious negotiation.

The AAMC had asked for an extension of the comment period to the more traditional 60 or 90 days to allow for a more orderly phase in of these caps.

Dr. Cohen also described the activities of the Council of Government Relations (COGR), which represents the business officers of the top 100 research universities. COGR, in consultation with the Association of American Universities, has developed a compromise position that has been presented to OMB. This position has three major provisions:

- 1) define departmental administrative costs more rigorously to limit them and eliminate the need for faculty effort reporting to document them;
- 2) freeze current administrative rate components for each university throughout fiscal 1987; and
- 3) suspend retroactive reimbursement of increases in indirect cost rate negotiated during the fiscal year.

The first proposal is intended to resolve the long-standing friction among OMB, the universities, and the research faculties over effort reporting and administrative costs that has resulted in some of the political pressures leading to the proposed revision of Circular A-21. The latter two proposals are expected to save OMB an equivalent sum to that which would have been saved by the 26 percent cap in fiscal 1986 and 1987. Dr. Cohen noted that the AAMC has written OMB in favor of COGR's proposal and requested that these changes be realized through a negotiation between OMB and representatives of both the faculties and university administrators.

## XII. ACGME AND ANESTHESIOLOGY

Robert Epstein, M.D., CAS representative from the Society of Academic Anesthesia Chairmen, discussed the recent action of the ACGME in response to a recommendation by the Residency Review Committee in Anesthesiology to approve a new curriculum for the 4 year training program in anesthesiology. The ACGME deferred action and returned the plan to the RRC for further clarification and review. Dr. Epstein explained that a number of members of the SAAC were concerned about the article on this action in the AAMC Weekly Activities Report. The anesthesiologists believe that this article misinterpreted their proposal, leading to concern that perhaps the AAMC was not fully informed when the ACGME considered this request.

Dr. Cohen noted that this issue was on the agenda for the CAS Administrative Board meeting on April 10.

ELECTION OF MEMBERS TO THE 1987 ADMINISTRATIVE BOARD

The 1986 CAS Nominating Committee met by conference call on June 2, 1986 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from that meeting is as follows:

CHAIRMAN-ELECT:

Douglas E. Kelly, Ph.D.  
Association of Anatomy Chairmen  
University of Southern California  
Los Angeles, California

THREE-YEAR TERMS:

Lewis Aronow, Ph.D.  
American Society for Pharmacology  
and Experimental Therapeutics  
Uniformed Services University  
of the Health Sciences  
Bethesda, Maryland

Herbert Pardes, M.D.  
American Psychiatric Association  
New York State Psychiatric  
Institute  
New York, New York

TWO-YEAR TERM:

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

ONE-YEAR TERM:

S. Craighead Alexander, M.D.  
Society of Academic Anesthesia  
Chairmen  
University of Wisconsin  
Madison, Wisconsin

Information about the nominees appears on the following pages.

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NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Douglas E. Kelly

Present Location (School) University of Southern California School of Medicine

CAS Society: Amer. Assn of Anatomists (President), Assoc of Anatomy Chm

Undergraduate School: Colorado State University (B.S. Zoology, 1954)

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

Stanford University, Ph.D., Biological Sciences - 1954-58

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Academic Appointments (with dates)

Professor and Chairman, Dept of Anatomy and Cell Biology, Univ of Southern California School of Medicine, 1974-present

Professor and Chairman, Dept of Biological Structure, University of Miami School of Medicine, 1970-74

Assistant and Associate Professor, Department of Biological Structure, University of Washington School of Medicine, 1963-70

Instructor and Assistant Professor, Department of Biology, University of Colorado, 1958-63

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Societies/Affiliations:

American Association of Anatomists - Current President

Association of Anatomy Chairmen - President 1977-78

American Society for Cell Biology

Association for Research in Vision and Ophthalmology

Society for Developmental Biology

\_\_\_\_\_

Honors/Awards:

Honor Alumnus - Colorado State University, 1978

Japan Association of Anatomists, Citation and Medal, 1984

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NOMINEES FOR CAS ADMINISTRATIVE BOARD  
FORM

Name: Lewis Aronow, Ph.D.  
 Present Location (School) Uniformed Services University of the Health Sciences  
 CAS Society: ASPET  
 Undergraduate School: City College of New York

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

M.S., Georgetown University (Chemistry), 1952

Ph.D., Harvard University (Pharmacology), 1956

## Academic Appointments (with dates)

Professor and Chairman, Dept. of Pharmacology, Uniformed Services University of the Health Sciences, 1976 - present.

Acting Chairman, Dept. of Pharmacology, Stanford University School of Medicine, 1974-76

Visiting Professor, Faculty of Sciences, Dept. of Biology, Universidad Central de Venezuela, June 15 - July 15, 1974

American Cancer Society/Eleanor Roosevelt International Cancer Fellow at University of Cambridge, England, 1970-71

Visiting Professor and Chairman, Pharmacology Dept., Escuela de Medicina Jose Vargas, Universidad Central de Venezuela, 1962-63

Instructor, Dept. of Pharmacology, Stanford University School of Medicine, 1956-59, Asst. Professor, 1959-62, Assoc. Professor, 1962-70, Professor, 1970-

## Societies/Affiliations:

National Board of Medical Examiners, Chairman, Pharm. Test Committee, Part I

American Society for Pharmacology and Experimental Therapeutics

American Association for the Advancement of Science (Fellow, 1966)

American Association for Cancer Research

Association for Medical School Pharmacology  
 Honors/Awards: Premio "Martin Vegas" 1964, Sociedad Venezolana de Dermatologia, Venereologia, y Ledprologia

Maloney Lecturer, Howard University School of Medicine, 1977

Secretary-treasurer, American Society for Pharmacology and Experimental Therapeutics, 1980

Pharmacy Alumni Lecturer, University of Toronto, 1980

USUHS Commendation Medal, 1981

Councilor, Association for Medical School Pharmacology, 1981

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: Herbert Pardes  
 Present Location (School) Columbia  
 CAS Society: American Psychiatric Association  
 Undergraduate School: Rutgers  
 Degree: B.S. Date: 1956  
 Medical School: Downstate Medical Center Year Graduated: 1960

Location and Nature of Major Graduate Training:

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

Straight Medical Intern, Kings County Hospital 1960-61

Resident, Psychiatry, Kings County 1961-62, 1964-66

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

Doctor of Medical Science Fellowship in Research, 1965-68

Board Certification:

Psychiatry, 1969  
(Specialty/Date)

Neurology, 1969  
(Specialty/Date)

Academic Appointments (With Dates):

January 1984 - Lawrence C. Kolb Professor and Chairman, Department of Psychiatry, Columbia University

1978-84 - NIMH Director

1975-78 - Chairman, Department of Psychiatry, University of Colorado Medical Center

1972-75 - Professor of Psychiatry, State University of New York  
Downstate Medical Center

1968-72 - Assistant Professor of Psychiatry  
State University of New York/Downstate Medical Center

1966-68 - Instructor, Psychiatry  
State University of New York/Downstate Medical Center

Societies/Affiliations:

American Psychiatric Association (Fellow) and Vice President

Society for Neuroscience

American Assoc. of Chairmen of Departments of Psychiatry (President-Elect)

Honors/Awards:

Founders Award/American Psychiatric Association

Public Health Service/Distinguished Service Award

Harlem Valley Distinguished Scholar Award

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

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

Location and Nature of Major Graduate Training:

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

Intern and Resident, Peter Bent Brigham Hospital, Boston, 1949-51

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

Board Certification:

\_\_\_\_\_  
(Specialty/Date)

\_\_\_\_\_  
(Specialty/Date)

Academic Appointments (With Dates):

University of California, San Francisco: Assistant Professor of Physiology,  
1955-60; Associate Professor of Physiology, 1960-64; Professor of Physiology,  
1965-82; Jack D. and DeLoris Lange Professor of Physiology, 1982-date;  
Chairman, Department of Physiology, 1970-date

Societies/Affiliations:

American Association for the Advancement of Science (Fellow); American  
Physiological Society (President, 1977-78); American Society for Pharmacology  
and Experimental Therapeutics; Association of Chairmen of Departments  
 (continued on back)

Honors/Awards:

Faculty Research Lecturer, UCSF, 1968; IFI Golden Hippocrates Award, 1970;  
ACDP Award for Outstanding Contributions to the Teaching of Physiology, 1978;  
A.A. Berthold Medal, German Endocrine Society, 1985; Various Named Lectures

Dr. William F. Ganong  
Page Two

of Physiology (President, 1976-77); Council for High Blood Pressure Research, American Heart Association (Fellow); Endocrine Society; International Brain Research Organization; International Society of Neuroendocrinology (Vice President, 1976-80); Society for Experimental Biology and Medicine; Society for Neuroscience (Treasurer, 1984-85).

NOMINEES FOR CAS ADMINISTRATIVE BOARD  
CV FORM

Name: S. Craighead Alexander, M.D.  
 Present Location (School) University of Wisconsin-Madison  
 CAS Society: Society of Academic Anesthesia Chairmen  
 Undergraduate School: Davidson College, Davidson, N.C.  
 Degree: B.S. Date: 1951  
 Medical School: University of Pennsylvania Year Graduated: 1955

Location and Nature of Major Graduate Training:

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

Internship - Philadelphia General Hospital, Philadelphia, P.A., 1955-56

Residency - Dept. of Anesthesiology, University of Pennsylvania, 1960-62

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

Department of Anesthesiology, University of Pennsylvania, 1962-64

Board Certification:

Anesthesiology, 1963

(Specialty/Date)

(Specialty/Date)

Academic Appointments (With Dates):

Instructor, Dept. of Pharmacology, Univ. of Pennsylvania (1958-60); Instructor,  
Dept. of Anesthesiology, Univ. of Pennsylvania (1960-63); Associate, Dept. of  
Anesthesiology, Univ. of Pennsylvania (1964-65); Assistant Professor, Dept. of  
Anesthesiology, Univ. of Pennsylvania (1965-69); Professor and Chairman, Dept.  
of Anesthesiology, Univ. of Connecticut (1969-71); Professor and Chairman, Dept.  
of Anesthesiology, Univ. of Wisconsin (1971-present)

Societies/Affiliations:

Association of University Anesthetists, American Society for Pharmacology &  
Experimental Therapeutics, American Medical Association, American Society of  
Anesthesiologists, Society of Neurosurgical Anesthesia and Neurologic Supportive  
Care, Society of Academic Anesthesia Chairmen

Honors/Awards:

Pharmaceutical Manufacturers Association Fellowship in Clinical Pharmacology (1959)  
Career Development Award, U.S. Public Health Service, (1965-69)  
Visiting Scientist, Bispebjerg Hospital, Copenhagen, Denmark, (1968-69)

Sigma Xi

ELECTION OF ACADEMIC SOCIETY MEMBERS

The following organizations are submitted for election to Academic Society membership:

Ambulatory Pediatric Association

American Association of Pathologists

Association for Surgical Education

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: Ambulatory Pediatric Association

MAILING ADDRESS: 1311A Dolley Madison Boulevard  
McLean, Virginia 22101

PURPOSE: The objective in the APA is the promotion of improved patient care, teaching and research in general pediatrics through the forum provided by its annual meeting, its regional meetings, its Newsletter, public recognition of outstanding teaching programs and special workshops on teaching and research methodology.

MEMBERSHIP CRITERIA: APA members must be involved in teaching those learning to deliver child health services and also be involved in either patient care or research in general pediatrics.

NUMBER OF MEMBERS: 1200

NUMBER OF FACULTY MEMBERS: 1100

DATE ORGANIZED: 1960

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

Revised 4/30/81 1. Constitution & Bylaws

May 6-9, 1986 2. Program & Minutes of Annual Meeting

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 Association of Pathologists, Inc.

MAILING ADDRESS: 9650 Rockville Pike  
Bethesda, MD 20814

PURPOSE: The purpose of the Association is the advancement and dissemination of knowledge of disease by scientific and educational means.

MEMBERSHIP CRITERIA: Any American investigator who has contributed meritorious work in pathology is eligible for active membership.

NUMBER OF MEMBERS: 2500

NUMBER OF FACULTY MEMBERS: Approximately 90 percent.

DATE ORGANIZED: Founded December 1900; reincorporated July 1, 1976

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

Adopted 1976

Revised 1979

1. Constitution & Bylaws

April 21-26, 1985

2. Program & Minutes of Annual Meeting

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: Association for Surgical Education

MAILING ADDRESS: c/o Norman Snow, M.D.  
Department of Surgery  
Cleveland Metropolitan General Hospital  
3395 Scranton Rd.  
Cleveland, Ohio 44109

PURPOSE: To improve undergraduate surgical education through the discussion and resolution of common problems. Among the objectives are: a) development of innovative teaching aids, b) research in surgical education utilizing a national data base, c) exchange of information to facilitate selection of internships, d) development of a national informational resource to aid individual surgical curriculum efforts

MEMBERSHIP CRITERIA:

Institutional: Surgery departments in medical schools and medical centers with teaching efforts in the U.S. and Canada  
Individual: Anyone interested in surgical education

NUMBER OF MEMBERS: 120-150

NUMBER OF FACULTY MEMBERS: Same

DATE ORGANIZED: 1980

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

1980 1. Constitution & Bylaws

1985 2. Program & Minutes of Annual Meeting

## REVISION OF THE CAS RULES AND REGULATIONS

In January, the Administrative Board recommended that the length of term for CAS representatives should be left to the discretion of the individual members' societies. Currently, CAS representatives are elected to 2-year terms, and individual representatives may serve up to four terms (or a total of 8 years). The Administrative Board felt that societies should be encouraged to appoint at least one representative to a term of sufficient length to allow the individual time to develop expertise with the issues of importance to the Council and the governance process of the Association. This recommendation met with approval by the Council at the Spring Meeting.

In June the Administrative Board agreed to modify the proposal so that the terms of the society representatives would begin at the same time as those of the Administrative Board members; i.e., following the Annual Meeting in the fall.

The following amendment of the CAS Rules and Regulations was approved by the CAS Administrative Board on September 11, 1986, with a recommendation that it be considered at the Annual Meeting of the Council on October 27, 1986.

### Section II. Representatives

1. The Council of Academic Societies shall consist of no more than two representatives from each member Academic Society of the Association of American Medical Colleges. These representatives shall be designated by each member Society. ~~for a term of two years;--provided, however, no representatives shall serve more than four (4) consecutive terms.~~ *The length of term for each representative shall be left to the discretion of each member Society. Member Societies are encouraged to appoint at least one representative to a term of sufficient length to become acquainted with the issues facing the Council. Terms for representatives shall begin and end at the time of the Association's Annual Meeting. Each member Society shall be informed one year in advance of the expiration of the term of its representatives, asking for the names of the representatives for the subsequent term.*

## REPORTING OF NBME SCORES

**Issue:** Should the AAMC take a position favoring the reporting of NBME examination scores solely on a pass-fail basis?

### Background

Prompted by the Organization of Student Representatives, the COD and CAS Administrative Boards discussed the issue of NBME examination score reporting at their June, 1986 meetings and the COD Administrative Board initiated consideration of the question at the meeting of the Executive Council. Spurred by the unanimous backing of the COD Administrative Board, the Executive Council voted to take the position that the AAMC should use its influence to encourage the NBME to report its examination scores solely on a pass-fail basis. The rationale for that position was that such a change would ameliorate the perceived negative influences of the examinations on medical education. Subsequent to that meeting, concerns were expressed that for such a position to be effective, further discussion within the AAMC constituency was desirable. This would assure the Executive Council that the position had the strong backing of the academic community which the AAMC represents. Thus, the question is being posed to the Council of Deans, Council of Academic Societies, Group on Medical Education, and Group on Student Affairs at their fall 1986 meetings. The Executive Council will consider the issue further at its January, 1987 meeting.

### Description and Implications of the AAMC Recommended Score Reporting Change

To understand the implications of the AAMC recommended change in score reporting, it is contrasted in Table 1 with the current score reporting scheme and a scoring scheme proposed by an NBME study committee for the new "comprehensive" examinations. It should be emphasized that this last scheme is only a committee proposal and not yet NBME policy.

Under the present system, scale scores (overall and by discipline) are reported along with a pass-fail status. This allows the examination results to be used not only to see which students pass minimum standards (licensure purpose) but also provides a comparison of individual student achievement. By aggregating and comparing scale scores, schools may and do use the results in curriculum/program evaluation at the departmental and institutional level. (Table 2 provides a statistical summary of the uses of NBME examinations in U.S. medical schools for the most recent year). It is these latter uses which are seen as having various stultifying effects on curricular reform and innovation (see arguments below). The major change in the scoring scheme proposed by the NBME study committee for the "comprehensive" examinations is the abandonment of individual discipline scores to students, although group performance data by discipline would continue to be available to schools in a manner similar to that reported currently. The committee proposal includes additional diagnostic score features, directed primarily to students who fail, which are not directly relevant to this discussion. The AAMC position would encourage further elimination of all scale scores in score reporting for Parts I and II, as unnecessary to the licensure purpose. The separate subject

(shelf) examination program of the National Board is expected to continue and presumably would not be affected by the AAMC recommended change.

### Discussion and Arguments

Proponents for a pass-fail only scoring system assert the following:

- 1) The historical purpose and chief value of the NBME examinations is the licensure of physicians. Scale scores make no contribution to this decision.
- 2) The reporting of scale scores tends to have various detrimental effects on medical education.
  - a) It reinforces the tendency for the examination to drive the curriculum. For example, it focuses the faculty's attention on the competencies and skills measured by the exam at the expense of other competencies of equal or greater importance. Also, the examination format tends to promote an excessive emphasis on memorization and information recall.
  - b) The need to make distinctions among a very able group of medical students invariably results in questions focusing on the recall of minutia having only a very indirect relationship to the knowledge and skills students should acquire.
  - c) Internal pressures to produce high scores stifle curriculum innovations.
  - d) It encourages faculties to abrogate their evaluation responsibilities to an external agency.
- 3) Scale scores are too easily abused. By the NBME's own assessment, the examinations evaluate only 25 percent of the competencies expected of graduating students. Yet these scores are viewed by the LCME as evidence of institutional effectiveness. Also, at times political bodies such as state legislatures request score information as a way of evaluating the institutions they support. Under such pressures it is difficult to decrease the emphasis placed on maximizing performance on the examination.

The counter-arguments presented including the following:

- 1) While licensure is the NBME's primary purpose, the examinations can serve other purposes, e.g., student evaluation, program (curriculum) evaluation, and institutional self-study.
- 2) Whatever disagreements exist about the importance of the material tested, the questions are written by medical school faculty members. Thus, it is not an external agency but our own faculties which are making judgments about the relevance of the material.
- 3) If abuses occur in the uses of the scores, the proper remedy is improved education on appropriate and inappropriate uses.

- 4) NBME scores are the single dependable numerical measure of competence and achievement referenced to national norms available to program directors who must assess a large number of applicants to residency positions.
- 5) The LCME's focus on NBME performance is primarily on the institution's failure rate. However, institutional score distributions, which would not be available if a pass-fail only score reporting was effected, can be quite valuable to the LCME in helping it identify areas of strength and weakness, particularly in newer schools where resources are not fully developed.
- 6) In the final analysis, each medical school faculty has the prerogative to determine institutional policy regarding the use of NBME scores. The information provided by scale scores should not be denied them.

### Conclusion

The role of NBME examinations and their influence on medical education has been discussed at the fall 1985 COD annual meeting program and various meetings of the COD Administrative Board over the years. The issue was directly addressed by the GPEP panel which suggested, in its 1984 report, that movement to a pass-fail scoring system would diminish "the heavy influence of these examinations on medical school educational programs." (p. 29). These concerns are pitted against assertions that the information provided by scale scores is of value to students, residency program directors and other medical school faculty members, the institutions themselves, and the LCME as an accrediting body.

The Council of Academic Societies is requested to consider whether the position taken but not as yet implemented by the Executive Council is one in which it supports. If not, the Council is requested to advise its Administrative Board of its views on alternative changes they would like the AAMC to recommend to the National Board as it prepares to develop policy on the new "comprehensive" examination program.

**TABLE 1**  
**CURRENT AND PROPOSED NBME SCORING SCHEMES**

	<u>Current</u>	<u>NBME Study Committee Proposal for the "Comprehensive" Exam*</u>	<u>AAMC Proposal</u>
Overall scale scores for Parts I and II	Yes, to students and schools	Yes, to students and schools	No
Overall pass-fail status for Parts I and II	Yes, to students and schools	Yes, to students and schools	Yes, to students and schools
Individual discipline scale scores for Parts I and II	Yes, to students and schools	No, but current group performance data reports to schools would continue	No

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\*The NBME Study Committee for Parts I and II recommended these changes in score reporting for the comprehensive examination. At present the process for developing the comprehensive Parts I and II examinations are just under way. The committees selected to steer the development will meet in September. Thus far, the NBME has not made a firm policy decision on how the results of the examinations will be reported either to the examinees or the medical schools. We are informed that this decision will most likely occur in 1987.

**TABLE 2**  
**USE OF NBME EXAMINATIONS BY SCHOOLS 1985-86**

	1985-86	
	No.	Percent (N=127)
<b>Use of the NBME Exam, Part I</b>		
Exam optional	29	22.8
Student must take exam	30	23.6
Student must take exam and achieve a passing total score	65	51.2
Student must take exam and achieve a passing score in each section	2	1.6
Scores used to determine final course grades	14	11.0
 <b>Use of Selected Sections of NBME Exam, Part I, by Department to Evaluate Students</b>		
Anatomy	3	2.4
Behavioral Sciences	1	.8
Biochemistry	9	7.1
Microbiology	8	6.3
Pathology	6	4.7
Pharmacology	5	3.9
Physiology	5	3.9
 <b>Use of NBME Exam, Part II</b>		
Exam optional	36	28.4
Student must take exam	38	29.9
Student must take exam and achieve a passing score to graduate	50	39.4
Scores used to determine final course grades	15	11.8
 <b>Evaluation of Educational Programs by the School Based on Results of the NBME Exams</b>		
	65	51.2

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Source: AAMC Curriculum Directory 1985-86

## CONCERN WITH DECLINING AUTOPSY RATE

Over the past 30 years in the United States, there has been a precipitous decline in the rate at which autopsies are performed on patients dying in the hospital. In 1950, the rate was about 50%; in 1984, it was 13.2%, and indications are that it continues downward. Much has been written concerning the implications for medicine of this decline. Many of the writers have focused on the untoward consequences for pathology, especially in relationship to research and the education of medical students in pathologic anatomy and pathophysiology. Only recently has it become recognized that historically the autopsy has had other, even greater values for medical students, particularly in teaching them about death and dying, the fallibility of physicians and the uncertainties of medical practice, and the importance of learning from one's errors. Thus, one of the results of the recent de-emphasis of autopsy has been the progressive decrease in exposure of medical students, and the consequent development of a philosophy on the part of recent graduates that doctors are perfect, that death is failure, and that autopsy is an outmoded procedure because all important diseases are accurately diagnosed during life. In view of this trend, one can foresee a profession dominated by physicians who embrace these misconceptions, that interfere seriously not only with progress in medicine, but also with doctor-patient relationships. In a recent survey, Chairmen of Departments of Medicine and Surgery, reported that they do not share this perception; they also provided their concerns about the strengths and weaknesses of the autopsy services in

their hospitals. Responding to these and other concerns, the Association of Pathology Chairmen recently appointed a task force to improve and increase the visibility and utilization of autopsy in academic medical centers, and the Institute of Medicine has called for a nationwide study to explore the need for a national autopsy policy.

The sociologist Renee C. Fox (University of Pennsylvania) has studied the non-cognitive education that takes place in medical students through involvement with autopsies, pointing out that at the autopsy table students must come to grips with a succession of unsettling ambiguities: awareness of the inadequacies of physicians, and thus of themselves as physicians, the limitations of medical knowledge, the difficulty of distinguishing between one's own inadequacies and the limitations of knowledge, the strong sense of defeat and helplessness that occur when a patient dies (Essays in Medical Sociology, Wiley-Interscience, 1979). Another sociologist, Helene Brown (UCLA Jonsson Comprehensive Cancer Center), has been looking at lay perceptions and reactions to autopsy, and the effect on doctor-patient relationships (Arch Pathol Lab Med, 1984, 108: 446). Stephen J. McPhee, an internist at University of California, San Francisco, has been interested in the same topic, as well as the general importance of autopsy to medicine and society (Am J Med 1985, 78:107; Am J Med 1986, in press).

In a recent evaluation of 32 hospitals and more than 2200 autopsies, Battle (a medical student) et al, evaluated a variety of environmental and patient-related factors, and their influence on the prevalence of major discrepancies between pre- and post-mortem diagnoses. Major discrepant diagnoses were defined as those that had implications of an adverse impact

upon survival: instances where recognition of the proper diagnosis pre-mortem would in all likelihood have resulted in the cure or prolonged survival of the patient (Abstract, Lab Invest 1985, 52:5a, ms in preparation). In a related study, Anderson and Hill examined the sensitivity and specificity of the pre-mortem diagnosis of six medical illnesses (cirrhosis of the liver, tuberculosis, chronic rheumatic heart disease, carcinoma of the stomach, leukemia, peptic ulcer) as a function of time. With the exception of peptic ulcer, surprisingly little change was found over a fifty year period, despite significant advances in the technology associated with medical diagnosis (ms. in preparation). Similar findings have been reported by Goldman et al (N Eng J Med 1983, 308:1000).

# THE WALL STREET JOURNAL.

WEDNESDAY, SEPTEMBER 24, 1986

## Fewer Autopsies Are Performed in U.S., To the Detriment of Medical Knowledge

By ALAN L. OTTEN

Staff Reporter of THE WALL STREET JOURNAL

The word "autopsy" is derived from a Greek term that literally means seeing with one's own eyes. Fewer doctors, however, are seeing with their own eyes these days, and as a result society may be losing insights into the causes and cures of a wide range of health problems.

Only three or four decades ago, about half of all people who died in U.S. hospitals received post-mortem examinations to establish the cause of death. Today, the rate is down to one autopsy in seven hospital deaths. Rates of 25% to 35% in major teaching hospitals are offset by rates of 5% or less in many community hospitals and probably under 1% in nursing homes.

"Invaluable knowledge is being interred daily with the unautopsied bodies," declares a forthcoming book by the pathologists Robert E. Anderson of the University of New Mexico and Rolla B. Hill of the State University of New York at Syracuse. Autopsy data, they say, can spot emerging diseases, monitor the accuracy of medical diagnoses and assess the effectiveness of new technology and techniques.

Alarmed at the steady decline in hospital autopsy rates, the College of American Pathologists is spearheading efforts to get the internists and specialists who attend dying patients to order more autopsies. But the professional organization hasn't had much success yet.

### Painstaking Work

In a typical autopsy, a pathologist takes two to four hours to dissect and painstakingly examine the body, then spends days or weeks in microscopic and other analysis of bodily material. Autopsies are usually ordered by public authorities in violent or suspicious deaths and those due to injuries and other trauma. In more-routine deaths, it is up to the patient's doctor to seek permission from the next of kin—and therein lies much of the current trouble.

Many doctors argue that CAT scans, ultrasound and other new diagnostic tools permit them to be reasonably sure why a patient died; unlike their predecessors, these doctors say, they don't need an autopsy to tell them. Also, fear of malpractice suits is often cited as deterring doctors from seeking autopsies: No matter how conscientious they were in treating a patient who died, they worry that an autopsy may turn up some slip that a clever lawyer could seize upon.

Doctors also dislike burdening the bereaved with yet another painful decision; families are often reluctant to have their loved one "cut up," because he or she "has suffered enough." The impersonality

of modern medicine, lacking the long relationship that the old-fashioned family doctor had with his patients, further limits the doctor's ability to ask for an autopsy and the family's willingness to agree.

"It is hard to put your arm around someone you barely know and say this is the thing to do, particularly if you yourself aren't convinced it is necessary," says Stephen A. Geller, head of pathology at Cedars-Sinai Medical Center, Los Angeles.

Economics also discourages autopsies. Medicare, private insurers and other third-party payers don't cover the \$1,000 or more that each autopsy costs. With cost-cutting pressures so intense nowadays, a procedure involving a person already dead is an obvious place for hospitals to economize.

"There isn't vocal opposition" to encouraging more autopsies, Dr. Hill says. "That would be like being against mother-

**'IT'S HARD to put your arm around someone you barely know and say this is the thing to do,' says a Los Angeles pathologist.**

hood. But there is a lot of foot dragging."

Most pathologists and many other medical experts question the arguments most often used against autopsies. The autopsy, they argue, is an essential check on whether the doctor diagnosed and treated a problem properly, whether the hospital provided proper care and whether the diagnostic tools were accurate. "Performed correctly, it is the ultimate control over the assurance of quality in the practice of medicine," says George D. Lundberg, the editor of the *Journal of the American Medical Association*.

Repeated surveys comparing autopsy results with pre-death diagnoses consistently find the diagnoses wrong, in major respects, 10% to 25% or more of the time. In many cases a proper pre-death diagnosis might have delayed or even prevented the fatality.

### A Teaching Tool

Autopsy advocates also contend that the dearth of autopsies costs medicine a teaching tool—one vital for older practitioners as well as medical students and residents. "I have never seen an autopsy you couldn't learn something from," says John Ball, the executive vice president of the *American College of Physicians*.

Perhaps most important, with fewer autopsies society loses valuable information

about novel diseases, occupational hazards and genetic disorders. Pathologists claim that autopsy findings established the link between cigarette smoking and lung cancer, discovered the cause of Legionnaires' disease, pinpointed how workplace exposure to the gas vinyl chloride leads to liver cancer—and are contributing much of what is known about acquired immune-deficiency syndrome.

Moreover, autopsies can provide information on genetic diseases that may be crucial to a family's health. Knowledge that their baby died of an inherited disease allows parents to seek genetic counseling before they decide to have another child.

### A Tragedy Seen

As a result, pathologists assert, the current low autopsy rate is a mounting tragedy. They say computers could feed autopsy results into a national data bank that scientists could search for evidence of new diseases and environmental dangers. And even though much more needs to be known about the special health problems of the swelling numbers of very old people, pathologists note, the elderly now are the people least likely to be autopsied.

"The way the world is moving—AIDS, environmental problems, new diet patterns—we may, without continuing surveillance by open minds, very well miss some major events," says Mitchell Rabkin, the president of Beth Israel Hospital in Boston.

What can be done to raise the autopsy rate? "When you lose the habit, it is hard to regain it," Dr. Geller warns. Some autopsy advocates want accrediting commissions to require each hospital and medical school to meet specific goals. Others urge the government and private insurers to pay more of the costs of autopsies.

But most advocates say the ultimate answer must be a long-term campaign to educate both the medical community and the public.

The Association of American Medical Colleges, the American Medical Association and the College of American Pathologists all have the subject up for discussion at this year's annual meetings. Other proponents of autopsies say hospitals should routinely discuss autopsy findings in staff conferences.

As for the public, many doctors argue that an autopsy can actually help assuage survivors' grief over the loss of a loved one; a family may be persuaded that a death wasn't meaningless if the autopsy's findings can help save other lives. Says Dr. Anderson, "The public must be educated to understand the importance of medicine's learning not just from its successes but also from its failures."

# CAS

COUNCIL OF ACADEMIC SOCIETIES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
1 Dupont Circle, N.W.  
Washington, D.C. 20036

September 26, 1986

TO: CAS Representatives

FROM: CAS Administrative Board

RE: Report of the Ad Hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency

Many medical schools, graduate education programs, faculty and students have in recent years become increasingly dissatisfied with the transition from medical school to residency training. An AAMC ad hoc committee, chaired by Spencer Foreman, M.D., was charged to identify the problems and develop possible solutions. A preliminary report to focus discussion was distributed in July to all AAMC members, including members of the Council of Academic Societies, as well as the specialty boards, residency review committees, and members of the American Board of Medical Specialities (ABMS) and the Council of Medical Specialty Societies (CMSS).

The CAS Administrative Board appointed a working group to examine the ad hoc Committee report and its recommendations in detail. The full Administrative Board discussed the report in September. As a result of these discussions and the comments received from faculty on the report itself, the Administrative Board has prepared an annotated version of the preliminary report, which it believes addresses many of the concerns that faculty may have with the report. In distributing this modified report to the Council for comment, the Board wishes to emphasize several points.

First, this is a working document. The AAMC Executive Council approved the ad hoc Committee's preliminary report for distribution to stimulate discussion of the issues raised in the report. The Administrative Board hopes that the Special General Session to discuss these issues on October 26 during the AAMC Annual Meeting will be the beginning of a meaningful interaction among all interested parties to resolve these problems and to improve the environment for both undergraduate and graduate medical education.

Second, this report addresses a broad range of problems and solutions. The Board urges you to consider each section carefully and independently, and not to focus exclusively on one set of recommendations. In its analysis of this report, the Board identified the following areas that it believes should each be considered on its own merits: Institutional Responsibility, Institutional Accreditation, The Quality of Clinical Education, Selection Criteria, Procedural Problems, Implementation.

Third; the Association and the CAS Administrative Board seek an open consideration of these issues and their resolution by all parties involved in the transition and in graduate medical education. The Special General Session is part of this process; the Council's discussion during its business meeting on Monday, October 27, is another. Active, informed participation by faculty is necessary for a meaningful discussion of these issues to take place. The Board's comments on the preliminary report are an attempt to emphasize the central concerns of medical faculty and promote full deliberation. Discussion should focus on whether the problems have been correctly identified and whether the proposed solutions are appropriate and feasible.

AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION  
AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY  
PRELIMINARY REPORT

The ad hoc Committee which convened to identify problems in the Transition and propose solutions circulated a report for constituency comment in July 1986. The CAS Administrative Board has considered the report and prepared this annotated commentary to facilitate discussion by the CAS Council. Text of the original document with some proposed revisions appears on the left side of the page and CAS Board Commentary on the right. The six key areas for discussion are:

1. Institutional Responsibility
2. Institutional Accreditation
3. Quality of Clinical Education
4. Selection Criteria
5. Procedural Problems
6. Implementation

September 1986

## Institutional Responsibility

Clinical medicine has evolved into a loose coalition of disciplines and subdisciplines with specialists in each principally identifying with and sharing the values and goals of their peers.

This allegiance to specialties <sup>may</sup> detracts from common understanding

among disciplines and fragments our institutions. Nowhere is

fragmentation <sup>has the potential to be disruptive</sup> more evident than in the organization and conduct

of graduate medical education.

The committee considered the question: "If there were greater institutional responsibility for graduate medical education, would problems at the transition be more readily solvable?" It was concluded that if each sponsoring institution had a system of academic governance for graduate medical education in place, solving problems generated by the selection process would be facilitated. A functioning governance structure could bring all of an institution's programs together to establish common policies and procedures for the selection of residents.

~~\*At present, who, how, and when students are selected for residency positions are the prerogative of each specialty program.~~ The selection practices of each specialty <sup>currently</sup> are attuned to the national practices of the specialty rather than to institutional policies and procedures. Thus, if nationally the programs in a specialty begin to use certain selection practices, each program follows <sup>this</sup> the national practice. Reinforcement of these practices by ~~internal~~ <sup>solely</sup> consultation within a specialty makes it very difficult for programs to accept arguments for changing how and when their candidates are selected. The committee believes that <sup>national</sup> institutional policies and procedures should govern who, how, and when residents are selected, rather than having them determined de facto, according to the national practice of each specialty.

## 1. Institutional Responsibility

This section proposes to give the institution, which is not specifically defined, rather broad responsibilities with regard to resident selection as an alternative to the current situation in which each specialty develops its own national procedure.

The CAS Administrative Board is concerned that, as currently worded, the report seems to simply replace the procedures of the individual specialties with those of individual institutions; thus, it proposes clarifying this section to stress common national rather than institutional procedures. In addition, the Board emphasizes that these procedures should address only the mechanics, the "how and when" of resident selection. The "who," that is, which applicants are selected, should remain the prerogative of each specialty.

The CAS Board does not see any rationale for a centralized application processing system within the institution because application for residency positions is made to the individual disciplinary programs. Compliance with institutional and national procedures should be attainable without imposing a cumbersome centralized pass-through of all applications.

As graduate medical education faces increasing pressures due to limited resources and potential manpower constraints, some process of institutional governance for graduate medical education will evolve. The CAS Board foresees the advantage of an academic governance mechanism for GME that ensures representation of all disciplines in addressing such key issues as resource allocation, quality control, and integration of training sites, as well as traffic rules for resident selection. Implementation of institutional responsibility for graduate medical education in such an interdisciplinary fashion should result in better integration and coordination of residency training programs within the institution.

It is recognized that establishing ~~common-institutional-poli-~~  
~~cies-and~~ <sup>national</sup> procedures is not sufficient unless each sponsored pro-  
gram abandons ~~nationally~~ <sup>specialty</sup> determined practices and adheres to in-  
~~stitutional~~ <sup>common</sup> rules. Therefore, the committee recommends:

- o That each institution providing graduate medical education  
~~develop common policies and procedures~~ <sup>adhere to</sup> ~~for all of its pro-~~ <sup>for selection of residents</sup>  
grams; and
  
- o That each institution establish a ~~central-administrative-sys-~~ <sup>system of academic</sup>  
~~tem-for-the-receipt-of-applications-and-the-announcement-of~~  
~~selection-decisions---This-system-should~~ ensure that all pro-  
grams adhere to ~~institutional-policies-and~~ <sup>national</sup> procedures.

## Institutional Accreditation

In its deliberations about the need for an academic governance structure for graduate medical education, the committee reviewed the General Requirements Section of the Essentials of Accredited Residencies that was adopted by the Accreditation Council for Graduate Medical Education and ratified by its five sponsors in 1981. The committee believes that the General Requirements provide a foundation upon which an institution can build an academic governance structure for graduate medical

*Such a governance structure would enhance the implementation of education. The finding that five years after their adoption the*

*of the General Requirements and assist the residency review committees General Requirements are rarely, if ever, applied in accreditation*

*in their accreditation decisions. tion decisions by residency review committees is strong evidence*

*that graduate medical education remains fragmented and specialty*

*specific.*

Compliance by an institution with the General Requirements should be a first order accreditation determination. Lack of compliance should jeopardize the accreditation of all of an institution's programs. The committee does not believe that each residency review committee can be expected to make a uniform decision about whether an institution is in compliance with the General Requirements. The committee recommends:

- o That the ACGME establish an institutional review committee empowered to determine institutional compliance with the General Requirements;
- o That the committee be composed of program directors, *representatives of basic and clinical faculty,* medical school deans, and teaching hospital directors, *and representatives of the housestaff;*
- o That a system be established to survey institutions periodically and independently of program surveys;
- o That for institutions accredited by the Liaison Committee on Medical Education (LCME), these surveys be coordinated with LCME surveys; and
- o That the accreditation decisions of the institutional review committee be communicated to, and be binding upon, each residency review committee.

## 2. Institutional Accreditation

The CAS Board believes that adherence to the ACGME General Requirements Section of the Essentials of Accredited Residencies can only strengthen institutional quality and buttress the accreditation standards of the residency review committees (RRCs). An institutional mechanism for academic governance will assure an institutional overview of the degree of adherence to the General Requirements, which the specialties collectively identified as essential to graduate medical education programs.

The prerogatives of selection of individual residency candidates by individual programs and development of specialty residency requirements by the individual disciplines are not at issue. The Board does not believe that institutional responsibility for graduate medical education should abrogate the authority of the RRCs to establish and enforce individual specialty standards for residency training programs. The RRCs will continue to make the judgements as to whether individual training programs meet the standards of the specialty. Identifying the resources necessary to improve programs that do not meet these standards should be a collective institutional responsibility.

The CAS Board agrees with the concept of accreditation of institutions by the ACGME for compliance with the General Requirements. The Board believes that an ACGME accreditation process would be complementary with the acknowledged role of the RRCs in establishing the special residency requirements. An ACGME institutional accreditation committee should have a broader representation of basic and clinical faculty and housestaff than is proposed.

### Specific Problems and Recommendations

Specific problems must be solved to ameliorate educational disruption at the transition. Some of these are largely within the control of the medical schools and should concern the Liaison Committee on Medical Education, which is responsible for determining the quality of medical student programs. Others are problems that must be solved by the mutual efforts of both medical school and graduate medical education authorities.

#### Medical School Problems:

Medical schools deans and their faculties have the ethical responsibility to ensure that graduates have attained a general professional education that imparts the knowledge, skills, values, and attitudes expected of all physicians. The intrusion of external forces that impair the accomplishment of this responsibility must not be permitted.

Some students, intent on making themselves competitive for selection in certain specialties and programs, have sought to interrupt their junior year's required sequence of clerkships to take electives, either at their own or other institutions. The

committee recommends:

- o That all students take the clerkships required by the Liaison Committee on Medical Education (internal medicine, surgery, pediatrics, obstetrics/gynecology, psychiatry, and, in some schools, family practice), only in the institution in which they are matriculated; and
- o That the satisfactory completion of an institution's required clerkship sequence precede the privilege of taking clinical electives elsewhere.

Many students increasingly devote their electives in the

senior year to the pursuit of a residency position. <sup>While</sup> The commit-

tee does not believe that a uniformly structured senior year

should be imposed upon all students. But, it strongly recommends that students' elective programs should be tailored to their completion of a general professional education that is consonant with their specialty choices and career plans. The committee recommends:

- o That each school establish an authoritative system to review <sup>in the clinical years</sup> and approve each student's elective sequence; and
- o That the Liaison Committee on Medical Education adopt accreditation policies to encourage the implementation of these recommendations.

### 3. Medical School Problems

The CAS Board concurs with these recommendations and believes it is the responsibility of each medical school and its faculty to scrutinize closely the clinical curriculum of its students and to take these steps to insure the quality and educational sequence of clinical clerkships and electives.

**Selection Criteria Problems:**

Program directors are intent upon selecting the most qualified graduates that they can. Their selection criteria are based upon students' knowledge, skills, and personal qualities. Medical school faculties responsible for evaluating students' achievement in these areas communicate their evaluations through

<sup>faculty letters,</sup>  
deans' letters/and transcripts. Some programs evidence a low

regard for these evaluations; ~~even doubting their candor.~~ As a result, a large number of programs require students to submit National Board of Medical Examiners scores, and some are even requesting Medical College Admission Test scores. To obtain what are perceived to be more reliable evaluations, informal networks of communication between clinical departments and program directors about candidates have evolved within disciplines. To observe candidates' performance, it is often suggested that they take an elective in a specialty at the institutions to which they are applying. This practice has led some students to take multiple electives in the specialty that they hope to pursue in their residencies.

The committee believes that these selection criteria problems can be solved and recommends:

- o That every medical school faculty inform their students at matriculation that their ultimate evaluation will consist of a balanced appraisal of <sup>the students' strengths and weaknesses</sup> ~~their weaknesses and their~~ strengths;
- o That those responsible for assembling evaluations and communicating them to graduate medical education programs adopt the principle that their responsibility is to provide a candid appraisal of students' weaknesses as well as their strengths; and
- ~~o That programs only require the submission of standardized test scores that have been demonstrated to have a significant correlation with clinical performance; and~~
- o That ~~all~~ programs abandon the practice of suggesting that candidates take an elective at an institution for the <sup>sole</sup> purpose of improving their chances for selection.

**4. Selection Criteria Problems**

The CAS Board agrees that written evaluations of medical students should be strengthened. Both Deans and faculty letters should accurately portray the student's characteristics and abilities. Such letters should be informative enough to permit residency candidates to be evaluated without on-site performance.

The Board disagrees with the implication that preclinical performance of students is not relevant to residency selection. It also feels that standardized test scores should not be categorically withheld from the residency selection process.

The Board feels that there may be legitimate reasons for a student to take a clinical elective at another institution, and is reluctant to prohibit all such electives.

**Procedural Problems:**

The procedural problems at the transition are largely related to timing. They are complicated by the large number of applications that must be processed both by the medical schools and by graduate medical education institutions and their programs. The committee believes that changes in the timing of the application and selection process and institutional systems to assist programs to process large numbers of applications can ameliorate the procedural problems.

The National Resident Matching Program (NRMP) is governed by all the parties concerned with medical students' and residents' education. Since its establishment, the NRMP has sought to adapt its policies and procedures to serve the needs of both students and graduate medical education programs. All graduate medical education programs should select senior students only through the matching program. The committee is convinced that further modifications to improve the program can be accomplished. A high priority for change is the schedule for submitting rank order lists and releasing match results.

The crucial dates in the NRMP schedule are in the second week in January, when students and programs must submit their rank order lists, and in the second week in March, when the match results are released. NRMP uses the two month period between these dates to computer code rank order lists and to obtain confirmation of their accuracy from both students and programs. The committee recommends:

- o That medical schools, teaching hospitals, and programs work together to ensure that senior medical students are selected for residency positions only through the NRMP;
- o That the NRMP explore every possible way to shorten the time between the submission of rank order lists and the release of the match results to one month;
- o That, if this shortening is accomplished, the rank order list deadline be moved to March 1; and
- o That the match results be released on April 1.

The lengthening of the period before rank order lists must be submitted from the present two weeks to two months after the December holidays will provide significantly more time for decisions by both candidates and programs. This schedule will also permit medical schools to incorporate evaluation of a portion of students' senior year performance into their communications to programs. The committee recommends:

- o That, if a March 1 rank order deadline is achieved, all medical schools and programs mutually agree on November 1 as the earliest date evaluations will be released by the schools.

The establishment of separate matching programs that occur in advance of the NRMP schedule by five specialties has contributed to the time pressures on both schools and students. The committee believes that these early matches, which were conceived before NRMP had adapted its programs to the needs of students applying to these specialties, are no longer necessary. The Committee therefore recommends:

- o That negotiations be undertaken to incorporate early matching specialties into the NRMP.

**5. Procedural Problems**

The CAS Board separates the issue of whether all specialties participate in a single national match for resident selection from when resident selection should take place.

Residents should be selected as late as possible in the senior year of medical school to avoid educational disruption, permit maximal input about medical school performance, and provide more time for the student to consider career choice seriously. The Board believes that beginning the resident selection process later in the year will "return" much of the fourth year to the medical schools and improve the students' clinical education.

The Board recognizes the unique and varying characteristics of residency programs in different specialties. However, it believes that a more integrated and coordinated approach to resident selection is desirable. All specialties selecting residents from the senior class should join in an effort to design an integrated selection system which will balance the needs of individual disciplines, medical schools, students, and the fourth year educational program. The resultant selection/matching process should be simplified and coordinated to reduce stress on students, deans' offices, and residency program directors. The NRMP should be structured to meet these needs.

The Administrative Board believes that a universal application form would significantly reduce the paperwork burden on students. At the same time, a centralized application process at each institution would not relieve and might possibly exacerbate paperwork for the institution because each discipline would still review its own applicants.

The committee considered the proposition that a national centralized application service be established to permit candidates to file only one application for distribution to all the programs to which they are applying. Such a service is not considered feasible. However, the committee believes that both the burden of filing applications by candidates and processing them by programs must be reduced as much as possible.

For candidates, the burden of filing applications can be reduced by the general acceptance of the universal application form developed by the AAMC and distributed by the NRMP. This four-page form has two pages for academic and demographic information that all programs require. It can be filled out once and reproduced. The other two pages are for information that is specific for a particular program or specialty and are completed for each program to which a student applies.

The Committee recommends:

~~The burden of processing a large number of applications can be alleviated by central institutional systems for this purpose. While selection decisions must reside with the programs, they can be relieved of much of the paperwork and record-keeping involved in the application process. At academic medical centers, the experience of the medical school admissions office in processing a large number of applications can be applied. The committee recommends--~~

- o That medical schools promote their graduates' use of the universal application form for graduate medical education;
- o That all graduate medical education institutions and their programs accept the universal application form as at least the first step in the application process; and
- ~~o That institutions develop central systems for handling the~~

~~paperwork and record-keeping for applications.~~

### Facilitating Changes in the Selection Process

The committee recognizes that to some the problems at the transition appear intractable. In part, this perception is due to a lack of opportunity for a mutual search for solutions through discussions among medical school deans, teaching hospital executives, and program directors. The committee senses that all parties are now concerned and are prepared to seek solutions. To facilitate both national and local deliberations, the committee recommends:

- o That institutional executives convene meetings of the <sup>residency</sup> program directors of <sup>their</sup> teaching hospitals to discuss their resident selection policies and procedures;
- o That the AAMC convene a meeting of the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals at its 1986 Annual Meeting to discuss this report;
- o That an ad hoc committee composed of representatives from <sup>CAS, COL, and CCTE</sup> ~~specialty-organizations-most-directly-involved-in-graduate medical-education~~ be convened by the AAMC, at least annually, for the next several years to review the progress towards solving problems at the transition between medical school and residency, and to discuss further measures to be taken; and
- o That analyses of the addendum to the AAMC's Graduation Questionnaire, which provides quantitative data on the effect of the selection process on students, be provided to guide discussions.

### 1. Implementation

The Administrative Board advocates formation of an ad hoc group to monitor the progress on the various issues identified in this report. Such a group should be expanded to include all parties involved with these transition issues.

## New Policies on Indirect Costs of Research

### Background

Between 1984 and 1985, both DHHS and Congress requested that the Office of Science and Technology Policy (OSTP) examine government-wide indirect costs reimbursement policies, especially with a view toward containing their increasing share of total extramural research costs. Between 1974 and 1984, indirect costs rose from 24.4 to 31.2 percent of total costs for NIH-funded research grants and from 24.6 to 26 percent for NSF-funded grants. OSTP responded in late 1985 with recommendations which were also contained in the subsequent report of the White House Science Council Panel on the Health of U.S. Colleges and Universities (attached). In essence, the Packard-Bromley Panel and OSTP attributed the NSF-NIH difference to agency differences in indirect costs policies and recommended DHHS adoption of NSF policies. They also noted that administrative costs, especially for departmental administration (DA) which included estimates of faculty effort in research administration, made up one third of all indirect cost reimbursement, while the combined total of DA plus the other administrative cost pools made up over half of the total rate. They concluded that all administrative costs should be fixed at the mean national percentage of modified total direct costs (MTDC) and faculty effort reporting eliminated.

### Proposal of fixed administrative indirect costs

OMB proposed in a Federal Register notice of February 12, 1986 to cap all administrative components at 26 percent of MTDC immediately, reducing to a ceiling of 20 percent by 1987. Strong dissent from the academic community led to publication of a revised OMB notice on June 9, 1986 which proposed to limit the fixed rate to the professional component of departmental administration only. Further revision and clarification has led to a final agreement whereby the faculty portion of indirect costs for departmental administration will be a uniform national allowance of 3.6 percent of MTDC. No faculty effort reporting will be required to support this fixed allowance, and its institution will prevent further growth in this portion of administrative costs. It cannot readily be ascertained whether this change will reduce current indirect costs. The AAMC hopes that this fixed allowance system will reduce contention between faculty and administrators over the legitimacy and documentation of these costs.

### DHHS Proposal to adopt NSF policies

On August 13, 1986, DHHS published its intent to adopt NSF policy on indirect cost payments by:

- 1) requiring that all grant applications show both direct and total costs requested,
- 2) paying in each grant fiscal year no more for indirect costs than was projected based on the institution's

provisional indirect rate in effect at the start of that year,

- 3) requiring prior agency approval for any rebudgeting of direct grant funds to indirect cost payments.

The proposal to prospectively fix a ceiling on indirect cost payments at the provisional rate in effect at the time of award represents a major policy shift for NIH/DHHS from full reimbursement of actual legitimate indirect costs incurred during the grant year. The stipulation that direct costs cannot be tapped to make up a shortfall in indirect costs would prohibit the practice, permissible under NSF awards, of recovering increased indirect cost rates despite the total award being fixed. DHHS estimates that this policy shift will "save" \$40 million yearly by forcing universities to bear any difference between indirect cost projections and actual legitimate expenses. However, these savings will be at the expense of tapping other university funds or reducing services to investigators.

While the Bromley-Packard Panel asserted that calling the attention of peer reviewers to indirect costs must somehow contribute to a general national pressure from scientists to control these costs, the Federal Register notice clearly stated that indirect costs on any given grant application were not subject to adjustment by the peer review groups. The Association is concerned that the duty of peer review groups to evaluate the scientific merit of proposals is not enhanced by providing indirect cost information, while the risk exists that this information will be misused for invidious comparisons between applications and distortion of the scientific merit basis of priority scores.

#### Discussion

Should indirect costs of NIH research grant applications be shown to peer review groups?

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Office of the Secretary****Grants Administration; Reimbursement of Indirect Costs**

**AGENCY:** Department of Health and Human Services (HHS).

**ACTION:** Notice of proposed change in departmental policy, requests for comments.

**SUMMARY:** The Department of Health and Human Services offers interested parties an opportunity to comment on proposed changes to its departmental policy concerning the reimbursement of indirect costs under those project grants and cooperative agreements where the Department currently reimburses full indirect costs. This policy is published in Chapter 6-150 of the HHS Grants Administration Manual.

Three major changes to Departmental policy are proposed. First, all grant applications reviewed by grant review panels would be required to show both the direct and indirect costs requested by the applicant. Second, the Department would, except in several specifically identified circumstances, no longer issue supplemental awards to cover indirect cost increases beyond the amounts originally awarded. Finally, the amount of indirect costs awarded would be treated as a ceiling: If actual indirect costs exceed that amount, the excess may not be charged to the grant without prior approval from the granting agency. A companion notice of proposed rulemaking, adding this prior approval requirement to the Department's grants administration regulations in 45 CFR Part 74, is published elsewhere in today's Federal Register.

We propose these changes in response to a recommendation by the Office of Science and Technology Policy that HHS adopt certain of the indirect cost reimbursement practices of the National Science Foundation and other Federal Departments.

**DATE:** Comments must be received by October 14, 1986.

**ADDRESS:** Comments on the proposed changes should be submitted in writing to Joel B. Feinglass, Director, Office of Assistance and Cost Policy, Department of Health and Human Services, Room 513D, 200 Independence Avenue, SW., Washington, DC 20201. All written comments pursuant to this notice will be available for public inspection during normal working hours at the above address.

**FOR FURTHER INFORMATION CONTACT:** John Strauch (202) 245-7565.

**SUPPLEMENTARY INFORMATION:****Background**

Rising indirect cost rates have been the focus of increasing concern by a wide spectrum of parties including Congress and Federal officials. Studies by the Congress, HHS, the Office of Science and Technology Policy, GAO and the HHS Inspector General have all addressed the subject in recent years. The Office of Science and Technology Policy (OSTP) recently reported that, starting from the old statutory ceiling of 20% (which was abolished in 1966), university indirect cost rates had grown by 1981 to a national composite of 30% at NIH and 25% at NSF, and by 1984 to 31.2% of total research costs at NIH. OSTP recommended that the Department adopt NSF practices of including the indirect cost portion of a research project budget in the application. This would mean that peer review groups would see the total funds being requested, and not merely the direct costs. OSTP indicated that under such a system the total amount of an award, both direct and indirect, should be fixed over the grant period. We propose to implement OSTP's recommendation by revising Grants Administration Manual Chapter 6-150 as indicated in the following sections.

**Peer Review**

At present, Departmental policy is silent on this subject. As a result practices of our awarding agencies vary. In the Public Health Service, peer review groups for research grant applications review the direct costs requested by research grant applicants but do not see the amount being requested for indirect costs. Other awarding agencies generally include both direct and indirect costs in the applications reviewed by such panels. Paragraph 6-150-201 of the proposed revision would require all applications reviewed by any grant application review panel to show both direct and indirect costs requested. This would enable reviewers to reach more informed judgments about the overall cost of proposed projects, because they would see the total estimated costs, and not merely the direct costs. However, the proposed vision states explicitly that the review panels would have no authority to change the indirect cost rates or restrict their application. Negotiating indirect cost rates would continue as the responsibility of the various negotiation offices of the cognizant Federal agency—in HHS, our Regional Divisions of Cost Allocation. Making sure that the rates are properly used would continue as the responsibility of grants management officials, financial management officials, or both, in our awarding agencies.

**Amount of Indirect Costs Awarded**

Under current policy, HHS granting agencies make supplemental awards, subject to the availability of appropriations, whenever the grantee's actual indirect costs allocable to grants exceed the amounts which have been awarded. These supplemental awards total about \$40 million annually. Paragraph 6-150-20 D of the proposed revision would eliminate this practice of providing additional funds, except in the following circumstances:

- (a) An error made by the granting agency in computing the award;
- (b) The restoration of funds previously recaptured by the Department as part of a grantee's unobligated balance;
- (c) New or delinquent grantees for whom valid rates are subsequently established; and
- (d) Expansion or extension of projects (limited to the indirect costs attributable to any additional direct costs awarded).

In addition, paragraph 6-150-20 D would provide that the amount of indirect costs awarded (or as subsequently amended) is a ceiling amount beyond which the grantee may not charge the grant except with the prior approval of the awarding agency. In other words, grantees would be required to obtain prior approval for any rebudgeting of grant funds from direct costs to indirect costs. Finally, paragraph 6-150-50 A.1.b. would be revised to eliminate the existing restrictions on an awarding agency's authority to reduce an award to reflect a lower indirect cost rate subsequently established (and thus reduce the indirect cost ceiling). As mentioned earlier, a companion proposal to add this prior approval requirement to the Department's grants administration regulations at 45 CFR Part 74 is published in today's Federal Register.

**Scope of Proposed Changes**

The Office of Science and Technology Policy's recommendation mentions only research grants. However, we believe that too many difficulties would be encountered in having a separate set of policies for non-research project grants. This would not be in the best interests of either the Department or its grantees. In addition, we believe that the issues are essentially the same in non-research programs. Consequently, we propose to apply the new policies to all affected project grants and cooperative agreements.

**Other Proposed Revisions**

In addition to the conforming changes needed throughout the chapter to reflect the policy changes discussed above, we are taking this opportunity to make a number of editorial improvements as well as changes to reflect current

terminology and Departmental organization. Also, we are clarifying the limited extent to which formula grants are affected by the chapter and the fact that policy concerning Public Assistance Programs is contained in a different chapter. Finally, we are proposing to reduce the time period for submission of summary expenditure report adjustment sheets from 1 year to 6 months and to recognize existing Departmental practice of not reimbursing indirect costs under grants to Federal organizations or in support of conferences.

#### Effects of Proposal

We cannot quantify with any assurance the effects of these proposed changes since we cannot predict either the extent to which rebudgeting will be approved by the awarding offices or the actions which may be taken by grantees to minimize the impact of these changes. We estimate as a maximum, that \$40 million, out of total annual indirect costs awarded of about \$1 billion, could be saved. In addition, some small savings for awarding agencies and grantees will result from eliminating many of the

grant amendments and financial report submissions now needed.

Accordingly, HHS proposes to amend its Grants Administration Manual as discussed above. Interested parties may obtain a copy of the proposed revised chapter 6-150 by contacting the Office of Assistance and Cost Policy at (202) 245-7565 or at the address provided in this notice for the submission of comments.

Dated: July 9, 1986.

Otis R. Bowen,

Secretary of Health and Human Services.

[FR Doc. 86-17586 Filed 8-12-86; 8:45 am]

BILLING CODE 4150-04-M

From: "A Renewed Partnership," Report of the White House Science Council Panel on the Health of U.S. Colleges and Universities, Office of Science and Technology Policy, Washington, D. C., 1986.

## IV. THE COSTS OF ACADEMIC SCIENCE AND ENGINEERING

*No nation can maintain a position of leadership in the world of today unless it develops to the full its scientific and technological resources. No government adequately meets its responsibilities unless it generously and intelligently supports and encourages the work of science in university, industry, and in its own laboratories.*

*President Harry S. Truman  
September 6, 1945*

### 1. Introduction

The combined efforts of government, industry and the universities have, over the years, given the United States one of the finest university systems in the world—both in scope, and in many quality measures as well. Through their tremendous diversity and accessibility, our universities have made the U.S. a world leader in science and technology. The evolution of the system has produced peaks of excellence in both public and private institutions, and across virtually all academic disciplines. Our universities continue to educate top-quality scientists and engineers, and to develop new scientific and technological insight and understanding.

In recent years, however, disputes have arisen over the costs of federally sponsored research at universities, over what those costs actually are and who should bear them. As disputes have intensified, the mechanisms for maintaining a healthy university system have broken down. For example, mistrust between universities and government agencies has led to micromanagement of the research enterprise by the agencies and the imposition of cost accounting paperwork burdens that reduce efficiency and creativity in both research and education. **The Panel believes that the time is ripe to reexamine the controversy over the costs of research and to create a system that maintains the health and excellence of our universities.**

### 2. The Costs of University Research

Because of the interweaving of education and research in U.S. higher education, it has never been easy to quantify the actual costs of university research. Some costs, such as those for specialized equipment, can be clearly related to research. Others, like utility costs, are more difficult since part is related to research and part to education. Accountants have divided the costs of research into two categories: direct and indirect costs. Direct costs are those attributable to specific projects—costs

such as time and effort of the principal investigator, project-specific research equipment, travel expenses and so on. Indirect costs are those not easily allocatable to specific projects; examples include the lifetime costs of laboratory space and research equipment, administration, utilities, etc. The separation into these two categories, direct and indirect, is arbitrary and differs from institution to institution.

When the federal government awards a research grant or contract to a university, it agrees to reimburse that university for a set of costs attributed to that particular project. The reimbursement includes both a direct and an indirect cost. (A detailed discussion of indirect costs can be found in Appendix F.) The amount of the grant is based upon the direct costs and an additional percentage of the direct costs to cover indirect costs. The percentage, known as the Indirect Cost Reimbursement rate, or ICR rate, is agreed to by negotiations between the federal government and the university. Currently, the Departments of Health and Human Services and Defense represent the federal government in such negotiations for all of the agencies that support work in a particular university. Generally, the university will compile documentation of all costs it classifies as indirect in a given time period and attempt to determine how much of each category of indirect costs is attributable to research. The total indirect costs attributable to federally funded research is then divided by the institution's total modified direct research cost reimbursement (the "organized research base") to determine that institution's ICR rate. The indirect costs attributable to unsupported research and to other institutional activities are borne by the institution.

The Office of Management and Budget Circular A-21 attempts to define the costs of research eligible for federal reimbursement (see Appendix F). It also establishes criteria for documentation and allocation of costs, and for negotiation between federal agencies and the universities. Circular A-21 provides a framework for discussion. It has not, however, significantly reduced the controversy over the costs of research.

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### 3. The Controversy Over Research Costs

There are three basic groups at odds in the controversy over the costs of research: faculty researchers, university administrators and government administrators. For each group, the combination of rising costs and slower growth in federal research budgets creates a different problem. To faculty researchers (and federal agencies) the problem is that indirect cost reimbursements are crowding out those for direct costs. Less and less of every research dollar is going to investigators and more and more to university administration. To university administrators, the problem is simply that reimbursements are not keeping pace with total actual university research costs. Government agencies are concerned that university research is becoming increasingly expensive at a time of increasing demands for the results of that research—talent and knowledge—and of limited federal research funding. They recognize that they will be under increasing pressure to increase the pace and scope of university research, and yet they are already in trouble funding it at its present level. They are also concerned that the research community is not, in their view, providing an adequate accounting to the taxpayers for the support received.

The controversy arises as the three groups try to reconcile their competing perspectives. Many faculty researchers, seeing their direct cost reimbursements crowded out by indirect cost reimbursements at a time when university bureaucracies often appear to them to be burgeoning, suspect that at least some indirect cost reimbursement claims are not entirely reasonable or necessary. These suspicions are reinforced by the perception that universities have few incentives to contain indirect cost reimbursements. Many government administrators, searching for ways to cut back on indirect cost reimbursements, are struck by the wide variation in ICR rates among institutions (see Table 3) and thus share with the researchers the suspicion that perhaps not all claims are reasonable and necessary. In addition, some government officials wonder whether it is even necessary or proper, particularly during a time of limited research funding, for the government to reimburse universities for all the costs they claim, even when those costs are legitimate.

It bears emphasis in any consideration of the variation of ICR rates that private and public universities really cannot be judged on a common scale. In general in the public institutions, state legislatures provide support for many aspects of infrastructure costs that in the case of the private institution become part of the federal indirect cost pool. In Table 3, for example, public institutions typically have ICR rates below 50 percent and private institutions in excess of 50 percent.

University administrators respond to faculty members and government officials with four points. First, they argue that the causes of the increases in indirect costs are real, citing as typical examples the needs for facilities and equipment, and growth in energy and library costs. The growing university bureaucracies, they contend, are a response to the proliferation of government red tape. Second, they argue that it is meaningless to compare indirect cost rates among institutions because of the variations in their accounting systems, geographical location, research orientation, age of physical plant and other differences. Third, universities argue that, despite charges to the contrary, they do have

significant incentives to contain indirect costs, inasmuch as the government reimburses only that portion of indirect costs that can be attributed to government-sponsored research activities, e.g., part of library costs. Universities have always had to bear a portion of these indirect costs. Also, there is constant pressure from the research faculty to keep the ICR rate down, particularly from those faculty members whose support is administered under the NSF mechanism (see later discussion on NSF and NIH mechanisms for ICR reimbursement). Finally, the universities argue that they do not even claim many legitimate costs of federally sponsored research and that being forced to bear a greater share of those costs only diverts scarce resources from other worthwhile campus activities, many of which contribute to the overall strength of the research and education enterprise.

As university research activities grow in scope, university officials increasingly point to the fact that such costs as fund raising, the bridging of investigators or research groups between externally supported projects and the provision of seed support required to initiate entirely new research activities (in industry federal IR&D allowances provide this support) are not allowed as components of indirect costs even though they play important roles in maintaining and improving the health and vitality of the overall university research activity. These costs too must be covered by institution resources.

The controversy over direct and indirect costs focuses on two issues fundamental to any understanding between the universities and the federal government. First, which costs should be considered reasonable and necessary to the conduct of sponsored research? Second, what share of those costs should the government bear? Mutually agreed upon answers to these questions will remove a major impediment to a smoothly operating relationship between the government and the universities.

**TABLE 3  
INDIRECT COST REIMBURSEMENT RATES  
AS A PERCENT OF DIRECT COSTS  
FISCAL YEAR 1985**

INSTITUTION	ICR RATE
Johns Hopkins	64.0
Univ. of California, San Francisco	30.6
Harvard Medical School	99.0
Harvard University Areas	62.4
Yale	68.0
Stanford	69.0
Columbia	74.1
University of Washington	40.0
Univ. of California, Los Angeles	43.0
University of Pennsylvania	64.0
Washington, St. Louis	51.0
Yeshiva	87.5
University of Michigan	50.0
University of Wisconsin-Madison	43.0
University of Minnesota	41.0
Duke University	50.0
Univ. of California, San Diego	38.5
University of Chicago	69.0
Cornell University	63.3
Cornell University Medical College	48.0
MIT	61.5
Univ. of California, Berkeley	44.0
National Average	49.3

#### 4. Indirect Costs

There has been almost no controversy over the reasonableness and necessity of direct costs; there has been much over the reasonableness and necessity of indirect ones. This imbalance both reflects and perpetuates the misperception that direct costs are somehow inherently more legitimate than indirect ones. In fact, both are real costs of research. A possible explanation for the differing perceptions may lie in the fact that in contrast to indirect costs, direct ones are universally subject to peer review and judged qualitatively in those reviews for their reasonableness and necessity. This process is accepted as legitimate by the federal government, the universities and the investigators. The assessments made by peer review individuals and panels as to how reasonable and necessary a research budget is are generally viewed as sound and credible.

Government reviews and audits provide scrutiny of indirect costs just as peer review does of direct costs. Federal indirect costs negotiators make on-site reviews of all indirect cost proposals before the ICR rates are negotiated, and some proposals are subjected to a full audit. These reviews focus on whether the proposed costs are allowable and relevant to the performance of research and on whether the institution's apportionment methods result in an equitable allocation of costs to research programs. Because these indirect costs relate to the institution's overall operations rather than to specific research projects, such reviews cannot—and do not—make an assessment as to the reasonableness of the institution's proposed indirect cost charges and allocations.

#### 5. The Documentation Problem

A further form the controversy assumes is over costs that are inherently difficult to quantify or justify. In an attempt to ensure that federal research dollars are being spent properly, the government has increasingly required documentation of research costs. Predictably, requirements to document costs are greatest where documentation is most difficult. In effect, the government attempts to legitimize through paperwork research costs that are difficult, if not impossible, to justify through other methods. This does not mean that such costs are inherently unreasonable, only that it is difficult to prove otherwise. In general, the government requires documentation on costs associated with federal research as well as on some that are not. In attempting to ensure that it is reimbursing the actual agreed costs of doing federally funded research, the government has imposed layers of documentation and administration requirements upon the universities. Such inefficiency and micromanagement is a natural corollary of a research funding policy based on the procurement approach (i.e. pay for whatever is needed, as it is needed). From the faculty member's perspective, the worst example of such red tape is, of course, faculty effort reporting. A workshop on effort reporting was conducted by the National Academy of Sciences; referring to faculty effort reporting, its members concluded that:

... the basic problem is that the requirements have been patterned largely after industrial practice—regular, after-the-fact reporting of time and effort ex-

pected. Such a scheme is not transferable to a university. Effort reporting forms call on faculty members to allot their time among a number of discrete functions. Most faculty effort, however, serves several ends at once and cannot be distributed rationally among discrete functions. An investigator working with a graduate student on a research project, for example, simply cannot divide such effort neatly into research and teaching.

By setting faculty, university administrators and government agencies against one another, faculty effort reporting works against the development of teamwork and of any sense of partnership in the enterprise. The reporting requirements serve to perpetuate controversy over costs that are inherently subjective and impossible to quantify, as well as creating animosity over the unproductive paperwork involved.

There are many other paperwork requirements which are equally inefficient and which serve to inhibit a healthy relationship between the universities and the government. The federal government, for example, now requires inventories of all research equipment owned by an institution, no matter how acquired, in order to compute use allowances. The government also requires exhaustive project-by-project documentation of research subcontracts to small businesses. Such requirements, even when laudable in original principle, work against the goal of efficient research.

None of the present documentation requirements promotes any greater consensus over what constitutes the reasonable and necessary costs of research. In addition to the damage they do to the university-government relationship, these requirements also obviously increase the administrative costs of federally sponsored research.

#### 6. Micromanagement of University Research

In addition, other requirements imposed by the federal government limit the flexibility afforded researchers in the management of their federal grants or contracts. In some agencies, the period of grants is as little as two years, and many must be reviewed annually. Renewal involves preparation of detailed accounts of both past and future work, and invites concomitant scrutiny and micromanagement by peer review panels and agency program officers. Researchers are rarely permitted to carry over unexpended contract funds from one year to the next. Equipment purchases over \$5,000 must be cleared through a local screening process, allegedly to prevent duplication. And perhaps most important of all, principal investigators, who are best able to judge the internal priorities of their research programs, are in some instances unable to transfer funding, for example, from other aspects of their programs to the support of graduate students and professional travel, without the explicit and time-consuming approval of agency program officers. The government, reacting in part to the controversy over the cost of research, has sought to increase accountability by imposing counterproductive regulations which impede flexibility, creativity and efficiency in university research.

The universities, in turn, have had little choice but to adopt a short-range belt-tightening view and, in consequence, have

done little to either mitigate the government's distrust or increase the flexibility of the enterprise in the face of government red tape. Their accounting systems are often arcane and antiquated, lending credence to the impression that they are not able to account for their costs. They have seldom initiated alternative organization structures, such as cross-disciplinary centers or block grants to groups of researchers, which might increase flexibility even despite federal regulatory limitations.

## 7. Mandatory Cost Sharing

Faced with the desire to reduce their research cost reimbursements to universities, Congress has decreed that for some agencies (e.g. NIH), the government should simply not bear all the costs of federally sponsored university research. Based on the concept that universities would be more determined to contain research costs if they are obliged to pay a portion of them, mandatory cost sharing was introduced as an incentive for the universities to be efficient in their management of the federal funds provided.

Despite the lack of any consensus underlying the policy, the government has applied this cost-sharing principle in other areas as well. In 1983, NIH indirect cost reimbursements appeared to be exceeding NIH's budgets. As a short-term solution, the agency attempted to reduce its indirect cost reimbursements by 10 percent across-the-board. It made no determination that the reimbursement claims exceeded the reasonable and necessary costs; the implication was simply that NIH would not agree to pay more than 90 percent of the costs claimed. This attempt failed because of active lobbying by the research community. Continuing dissatisfaction with the perceived shortcomings of the indirect cost reimbursement procedures ensure that the issue will not disappear. Other, more drastic proposals, such as an indirect cost reimbursement based on a fixed 25 percent of direct costs, have recently been considered seriously by OMB.

## 8. Indirect Cost Reimbursement

There is a final issue—the ways in which indirect costs are determined and reimbursement policies put into practice. Federal agencies which sponsor university research currently employ two somewhat different methods for calculating research cost reimbursements. Both are based on OMB Circular A-21. At NIH, which funds half of the federally sponsored university research, research proposals include only the direct project costs. Peer review panels then consider only the direct portion of the budget; if an award is granted, the institution's current indirect cost reimbursement rate is applied automatically by the agency. In multi-year grants, should this rate rise during the term of the grant, the indirect cost reimbursement rises accordingly.

At NSF, and all other major federal research agencies, reimbursement practices are similar, but their effect is in practice somewhat different. At these agencies, research project budgets include the total proposed costs—the direct cost components (as in the NIH practice) plus the indirect cost reimbursement. Prior to an award, the total cost is negotiated by the principal program officer on behalf of the agency and by the principal investigator

on behalf of the institution. Under this system, since the total is usually, but not necessarily, fixed over time, if the indirect cost rate increases, the direct cost reimbursement—those funds available to the researcher—is reduced.

The practical and political differences between the two systems are noteworthy. Both systems are subject to the same institution-by-institution indirect cost rates negotiated by DOD or HHS on behalf of all federal agencies. But the NIH system tends to be more closely associated with the "indirect cost problem" than does the NSF system. When the GAO undertook to study the "reasonableness of rising indirect costs," it was NIH that was the focus of the study. And statistics show greater growth in NIH reimbursements for indirect costs than in comparable NSF reimbursements. In 1966 when the government removed the 20 percent fixed rate on indirect costs, the ratio of indirect to total cost reimbursements was the same (20 percent) at both NIH and NSF (See Appendix G). By 1981, that ratio was 30 percent at NIH, but only 25 percent at NSF. And whereas NIH's ratio continues to grow, NSF's has remained relatively constant.

Another reason why NIH has been more often associated with the "indirect cost problem" is that its system subjects fewer cost components to internal pressures within a given institution than does the NSF system. In the NIH system, the researcher is concerned only with the direct costs of research, and indirect costs are the concern of a university administration negotiator and the negotiator at HHS or DOD. In the NSF system, the researcher sees each dollar of increased indirect cost recovery subtracted directly from the amount available for research; it is thus an issue between the investigator and his university's administration. In the former, the researcher argues with Washington; in the latter, with university administration colleagues. In the NIH system the pressure is on government agencies to balance rising costs against fiscal limitations; in the NSF system the pressure is on the universities. In the NSF system, therefore, faculty are likely to be immediately aware of, and thus bring pressure to minimize, actual indirect costs, thereby working to keep ICR rates down.

Finally, and perhaps most important of all, is the way in which the two systems affect the indirect cost controversy. The NSF system is more likely than the NIH system to be accused of incomplete reimbursement, since the agencies do not adjust the total amount of a grant to absorb possible increases in the applicable ICR rate during the term of the grant. Conversely, it is less likely to be accused of reimbursing for more than the reasonable and necessary costs of research, since the NSF system encourages faculty and university administrators to debate the indirect costs.

Several conclusions can be drawn from this analysis. First, since there has been almost no controversy over direct costs, one can conclude confidently that the peer review system is a sound, credible and effective mechanism for distinguishing reasonable and necessary costs from unreasonable and unnecessary ones. Second, because faculty pressure works to minimize indirect costs, the Panel believes that the NSF reimbursement system is preferable to the NIH one and that no obvious benefits accrue from the present dual system. **We therefore recommend that all federal agencies supporting university-based research**

**take steps to adopt the NSF practice for indirect cost reimbursement.**

This should not become an invitation to NIH study sections to promanage the details of project budgets. The members are not likely to be well informed about the structure of indirect costs, nor about the negotiations and audits in which each institution engages with the government. The project review staff at NIH can be appropriately educated and may then be able to guide the peer review mechanisms in ways consistent with the agency's policy. There is no reason, however, for total project costs (including indirect) to be concealed from the review process.

## 9. Conclusions

The attempts to define precisely the costs of research at universities have resulted in excess of paperwork that is self-defeating, and a constant source of stress between government managers, faculty, and university administrators. As an example, the mandatory cost-sharing concept has generated paperwork and consumed resources, but has resulted in nothing of value. It should be recognized that support of personnel, support of students, and the provision of an environment conducive to the conduct of research and training, in themselves constitute cost sharing. Documentation neither adds to nor subtracts from this.

Similarly, the need for faculty effort reporting results in a totally artificial separation of the multiple overlapping responsibilities of university faculty members. Since the active research effort is also a training function, since a single laboratory may have several related grants, since participation in university and departmental governance also involves administrative functions related to management of federally supported research, and, particularly, since no faculty member works as little as forty hours a week, the formal effort reporting requirements are simply administrative fictions.

These examples are perhaps the most striking, but by no means the only, manifestations of what can only be called bureaucratic accretion. Although the need for accountability which spawned these procedures is understandable, the outcome is, on balance, counterproductive to the goals of all involved. Some attempt at simplification is desperately required.

The indirect cost issue has caused similar, and perhaps even more severe, problems. In summary, indirect costs can be divided into infrastructure and administrative costs. Virtually all the controversy centers on the administrative costs and, in particular, the apparently puzzling variation in rates from institution to institution. As described in Appendix F, there is justification for this diversity. However, the effort reporting, the bureaucratic burdens, the increasing divisiveness, and the

damage done to the university-government partnership that flows from the present continuing institution-by-institution negotiation of indirect costs cannot be justified.

In conclusion, the Panel strongly recommends that the federal government agree to bear its full share of the cost of university-based federally supported research. This would entail an understanding that cost sharing is inherent in the resources that universities bring to the research effort. In order to ease the stresses resulting from negotiated indirect costs, a single level for the administrative component of indirect costs should be established. In parallel, a reduction should be made in the unnecessary and overly burdensome paperwork associated with grants and contract management; elimination of the effort reporting that will follow from our recommendation for the fixing of the administrative component of the indirect cost pool will, in itself, go a long way toward reducing the friction in the government-university interface and the real level of indirect cost.

## 10. Recommendations

1. The federal government should bear its full share of the cost of university research it supports.
2. Reimbursements for administrative costs within the indirect cost category should be fixed at a uniform percentage of modified total direct costs. That percentage should be the mean percentage over a five-year historical period, and the adjustments should be phased in over a two-year period to allow those universities now charging more than the new fixed rate to plan for reduction. This change will eliminate much of the need for faculty effort reporting.
3. The formal requirement for cost sharing should be eliminated.
4. The paperwork burden associated with grant and contract administration should be reduced to a minimum. In the Panel view, all faculty effort reporting should be eliminated.
5. All federal agencies supporting university research should adopt the NSF practice of including the indirect costs in the project budget subject to peer review.

**The Panel recognizes that some universities will face reduced indirect cost reimbursements if our recommendation concerning administrative costs is implemented. We emphasize, however, that our recommendations concerning more realistic use allowances for facilities and equipment are designed, in part, to offset such reductions. It is therefore of special importance that our recommendations be considered as an integrated package; were they to be only partially or selectively implemented, they could result in significant damage to the academic enterprise.**

## APPENDIX F

### Indirect Costs

#### The Components of the Indirect Cost Pool

To better understand the controversy, it is helpful to disaggregate the indirect cost category into its component cost pools. Under the present framework established in OMB Circular -21, indirect costs are divided into the following pools.

Indirect Cost Pool	Average Indirect Cost Reimbursements in 1984
(1) Operation and Maintenance (utilities, janitorial services routine maintenance, etc.)	28%
(2) Use Charges for Buildings and Equipment (or depreciation of institutional assets)	10%
(3) Libraries (books and materials, salaries, expenses and fringe benefits of librarians and library staffs)	4%
(4) Student Administration and Services (costs of registrar, deans of students, student advisors, health services, etc.)	1%
(5) General Administration (salaries, expenses and fringe benefits of university officials and university-wide offices, such as personnel, accounting and payroll)	15%
(6) Sponsored Projects Administration (salaries, expenses and fringe benefits of administrators and staff in offices set up to administer sponsored research programs)	7%
(7) Departmental Administration (salaries, expenses and fringe benefits of personnel [e.g. chairmen, secretaries and faculty] in academic departments and divisions, and organized research units attributable to administration activities)	33%

In essence, these seven pools are actually subdivisions of two types of costs: the first three may be considered infrastructure costs, and together they currently amount to approximately 23 percent of costs, on average. The second four are administrative costs, and together they amount to about 26 percent of direct costs, on average. Together, university indirect costs now constitute, on average, almost one-third of total research costs, or half of direct costs.

#### 2. Infrastructure Costs

There is no universally applicable rule of thumb for determining what are reasonable and necessary costs of infrastructure. Institutions have different expenses according to their age, geo-

graphic location, disciplinary specialities, etc. But determining the infrastructure costs at a single given institution is not especially mysterious. The costs are relatively easy to document, and the types of costs do not vary significantly from institution to institution. The controversy over the costs of facilities and equipment, however, does not involve uncertainty as to how they are determined: rather the uncertainty is over whether, or to what extent, they are recognized by all parties as legitimate, reasonable and necessary costs of research. In the last decade and a half, universities and government have been unable to agree on these matters.

In fact, the costs of research facilities and equipment are reasonable and necessary costs of research. Modern research is impossible without modern laboratories, libraries, instruments and computers, and the health of the university system is fundamentally dependent upon the condition of these items in the universities. In order to fund the capital investments necessary for the establishment of such facilities, many universities have undertaken substantial indebtedness through direct borrowing or the issuing of bonds. We have recommended substantial changes in the regulations governing use allowances for facilities and equipment in order to more nearly reflect the actual situation in the universities.

#### 3. Administrative Costs

The controversy over administrative costs is quite simply over which costs should be considered reasonable and necessary. Central to the controversy is the matter of administrative costs. At a time when indirect cost reimbursement rates are rising, many researchers suspect that some of the costs claimed for departmental and sponsored projects administration activities are, in fact, neither reasonable nor necessary. Departmental administration costs are regarded dubiously because they are computed substantially on the basis of faculty effort reporting; sponsored project administration costs are also based in part on effort reports and—in the view of many researchers—reflect a haven for unproductive bureaucrats. By and large, the universities have defended ICR rate increases by pointing to increases in infrastructure cost pools, while researchers and government representatives have complained about ICR rate increases by pointing to administrative cost pools.

In 1983, in its study of the costs of federally funded R&D, the President's Private Sector Survey on Cost Control—the Grace Commission—issued its *Task Force Report on Research and Development*. With respect to administrative costs, the report concludes:

The administrative components of the indirect cost rate (departmental administration, general and administration, and sponsored project administration) are the most difficult components to establish on the basis of documented, objective evidence and further attempts to reach a compromise on acceptable forms of docu-

mentation will only create more friction and frustration. Instead fixed rates should be negotiated and the ongoing requirements for documentation of actual rates should be eliminated.

It further recommends:

The cognizant agencies should negotiate indirect cost rates that include a fixed rate for the administrative components and relieve the universities of the main portion of the burden associated with effort reporting.

A report released in March 1984 by the General Accounting Office (GAO) entitled, *Assuring Reasonableness of Rising Indirect Costs on NIH Research Grants—A Difficult Problem*, states:

Departmental administration expenses are subjective and not easily verified (p. iv), [and notes that such costs] will undoubtedly be the source of continuing controversy. (p. vii)

The Panel finds itself in full agreement with these findings and with the Grace Commission recommendation.

Government representatives, researchers and university administrators all described departmental administration costs in terms similar to those used by the Grace Commission and by GAO. Departmental administration comprises some 30-35 percent of indirect cost reimbursements (60-70 percent of administrative cost reimbursements), the largest fraction of any indirect cost pool and twice as large a fraction as the next largest administrative pool—general administration. While university administrators will generally acknowledge that faculty effort reporting is nonsensical and that departmental administration expenses are thus difficult to justify, they contend, with some argument from the government and the researchers, that reimbursements for the three remaining cost pools (general administration, sponsored projects administration and student services) reflect reasonable and necessary administrative costs.

The next most controversial administrative pool after departmental administration, sponsored project administration, accounts for about 8 percent of indirect cost reimbursement and covers the administrative costs associated with the actual federal grant and contract process. It has two components. The first is the cost of operating separate organizational units established specifically to administer federal grants and contracts; the second covers administrative activities outside of the separate units which benefit federally sponsored programs exclusively. This latter component is based, to a large extent, on faculty effort reporting and is thus subject to the same controversy as departmental administration.

Reimbursement for student services administration is not large enough at most universities to be significant.

Finally, there is the general administration category, which includes the costs of the central administration of the institutions involved and various other miscellaneous administrative items. Although it currently represents about 15 percent of indirect reimbursements, the general administration category has not been subject to significant controversy. Furthermore, it has not shown the sort of growth recently characteristic of the other administrative pools.

#### 4. Diversity and Variation in Administrative Rates

Clearly, one of the strengths of the U.S. higher education system is the diversity that has allowed the system to develop centers of excellence, institutions with unique capabilities and a degree of accessibility unmatched in the world.

The universities contend that the present indirect cost reimbursement mechanism, by basing reimbursements on documented costs, is flexible enough to reflect and help maintain this diversity. The present cost allocation mechanism, however, stimulates confusion over the manner in which already controversial costs are reimbursed. Similar administrative costs can be charged to a number of different cost pools—direct or indirect, departmental administration or sponsored projects administration, etc. A paper prepared for the Panel by the Council on Governmental Relations (COGR), an association of university financial officers lists, by example, a number of costs that are classified differently at different institutions. Many of the differences in classification reflect differences in internal organization. As the paper notes,

Essentially, the variety of methods used to group and allocate costs was basically the result of the variety of organizational structure.

These structures in turn reflect variation in an enormous number of individual institutional characteristics.

One of the questions the COGR analysis sought to answer was why many seemingly similar institutions have such dissimilar administrative cost rates in both the aggregate and within specific component pools. It concluded that there are four principal reasons for differences in aggregate administrative cost rates from institution to institution:

1. Similar administrative costs may be charged indirectly at one university and directly at another.
2. The same costs may be regarded as administrative costs at one university and as operational or plant costs at another (more likely, as one administrative pool at one university, another at another).
3. Excluding costs from the aggregate direct category can cause the same amount of administrative costs to be reflected in a different ICR rate.
4. How vigorously an institution accounts for costs, and negotiates reimbursements, may affect the amount charged to administrative pools.

The first three of these reasons, according to the COGR report:

result in shifting of costs among various indirect and direct cost categories; the remaining reason results in modifications in the total amount of costs claimed.

The primary reason why the total administrative costs charged differ from institution to institution is simply that institutions differ in the degree of vigor they apply to accounting for, and charging for those costs. The Panel concludes that there does not appear to be as much variation in actual administrative costs as the diversity in the system might suggest.

#### 5. The GAO Recommendation

To resolve some of the current controversy, the 1984 GAO report recommends that OMB amend Circular A-21 to fix reim-

bursements for departmental administration as a percentage of direct reimbursements, replacing the "cost reimbursement" method now used. The reimbursement, suggests the GAO report, could vary on an institution-by-institution basis, depending on their individual circumstances, but should not rely on effort reporting to represent those circumstances. The reimbursement should represent a reasonable amount needed for effective research administration at the departmental level of each institution. The GAO report followed a similar proposal by HHS contained in a 1983 report to Congress.

#### **6. The Stanford and Yale Agreements**

In the meantime, two universities, Stanford and Yale, have undertaken to deal with the problem individually and ease their

paperwork burdens, reduce their administrative costs and eliminate some of the adversity created by the ongoing indirect cost controversy. Each university negotiated a fixed rate for departmental administration in exchange for reducing effort reporting requirements. Both agreements have finite durations: Stanford's must be renegotiated after five years; Yale's after four. Both institutions, according to the NAS Workshop on Effort Reporting in A-21 made financial concessions in their agreements, but did so on the stated grounds that the financial loss was outweighed by the intangible gains in the morale and spirit among researchers, and a greater collegiality among researchers and administrators.

## APPENDIX G

### A Summary History of Indirect Costs

#### 1950-1965

Cost principles for indirect cost reimbursement formally worked out, and published in a Bureau of the Budget Circular A-21 in 1958. The Department of Health, Education and Welfare set a fixed upper limit on indirect cost recovery for grants. This was 8 percent initially, changed to 15 percent in 1958, and 20 percent in 1963.

#### 1966

Indirect cost ceiling removed. Cost-sharing required by law in the Department of Health, Education and Welfare Appropriations Act.

#### 1975-1979

Sixth revision of Circular A-21. Revised requirements for effort reporting and standard basis for distributing costs among projects.

#### 1982

Seventh revision of Circular A-21. Effort reporting requirements eased, and interest expense made allowable in specific circumstances.

## PHS POLICIES FOR DEALING WITH MISCONDUCT IN SCIENCE

In a special issue of the NIH Guide for Grants and Contracts, the PHS published its policies and procedures for dealing with possible misconduct in science (Vol. 15, No. 11, July 18, 1986). Included were detailed procedures for PHS agencies that make extramural awards, a summary of procedures affecting FDA regulated research, and procedures for investigating misconduct in intramural PHS research. Comments on the PHS policies were solicited from the research community and will be considered in subsequent revisions, although all of the procedures are currently in use by PHS/NIH. Awardee institution responsibilities as outlined in the Guide closely parallel the recommendations of the 1982 AAMC report, "Maintenance of High Ethical Standards in the Conduct of Research." Specific procedures to assure PHS of awardee institution compliance will be contained in a Federal Register notice later this year, as will changes to the NIH record-keeping system, ALERT for Misconduct in Science, to make it PHS-wide.

The policies for extramural granting agencies and grantees are attached. Scientific misconduct is defined as 1) "...fabrication, falsification or plagiarism...in carrying out...or reporting...research, or 2) material failure to comply with Federal requirements...e.g., the protection of human subjects and the welfare of laboratory animals." A two step procedure is to be followed in responding to allegations of misconduct. Upon receipt of an allegation, the awardee institution should determine within 30 days if formal investigation is warranted. The granting agency must be notified of formal investigations, which should be completed within 120 days (p.76-78). While stating that primary responsibility rests with the institution, the policy includes a description of granting agency inquiry/investigation procedures upon receipt of an allegation or institutional report which raise the spectre of dual investigations (p. 61-78).

Misconduct Policy Officers (MPOs) in each institute and PHS agency as well as appropriate institute directors will be informed of ongoing investigations. National Advisory Councils but not study sections will be advised of investigations related to competing awards (p.65). A PHS ALERT system will ensure that need-to-know officials are alerted to ongoing investigations and sanctioned individuals/institutions (p. 62, 66, 76). Interim administrative action can be imposed in serious cases to protect the public interest prior to the completion of the investigation (p.69-70). At the completion of the investigation, innocent parties will be exonerated and those shown to have committed scientific misconduct may be sanctioned by the grantee institutions and by the PHS awarding agency according to the seriousness of the offence (p. 71-75).

Points for Discussion

1. Should the accused scientist's institution have primary responsibility for investigation? If so, do you think the policy clearly cedes that responsibility?
2. Is the time frame for inquiry/investigation appropriate? Should the granting agency be notified as soon as a formal investigation is launched?
3. Who within the granting agency should be apprised of ongoing investigations? Is the need-to-know agency staff limited enough? Do you agree that study sections should not know that a grant applicant is being investigated, but Advisory Councils should be informed?
4. Do you agree with the prerogative of the granting agency to take interim administrative actions during an investigation? Is the range of possible actions appropriate?
5. Is the range of sanctions for proven misconduct appropriate?

INTERIM PUBLIC HEALTH SERVICE  
POLICIES AND PROCEDURES FOR DEALING WITH  
POSSIBLE MISCONDUCT IN SCIENCE

Policies and Procedures  
For  
Agencies and Programs Authorized to Make Awards  
for Research and Research Training

APPLICABILITY

The policies and procedures described in this document apply to all instances of possible misconduct involving research, research training, or related activities for which Public Health Service (PHS) funds have been provided or requested. This guidance is an extension of the PHS General Policies and Principles for dealing with alleged or apparent misconduct in scientific activities conducted, funded, or regulated by the PHS. Issues that are not primarily scientific are outside the scope of these procedures.

DEFINITIONS

"Misconduct" is defined as (1) serious deviation, such as fabrication, falsification, or plagiarism, from accepted practices in carrying out research or in reporting the results of research; or (2) material failure to comply with Federal requirements affecting specific aspects of the conduct of research, e.g., the protection of human subjects and the welfare of laboratory animals.

"Funded by," means the provision of monetary support for grants, cooperative agreements, fellowships, contracts, or interagency agreements, and includes subgrantees, subcontractors and individuals who work on the funded research project even though they do not receive compensation from the Federal funds.

"Investigator" means the principal investigator, the co-investigator(s), the program director or trainee on a training grant, the recipient of a career award or fellowship, or other individual who conducts or is responsible for research or research training funded by the PHS.

An "Inquiry" consists of information-gathering and initial fact-finding to determine whether an allegation or apparent instance of misconduct warrants an investigation.

An "Investigation" is a formal examination and evaluation of all relevant facts to determine if an instance of misconduct has taken place. If misconduct has already been confirmed, an investigation may, nevertheless, be conducted to determine the extent of any adverse effects resulting from the misconduct.

The PHS ALERT for Misconduct in Science is a system for collecting, controlling, and disseminating to PHS officials on a need-to-know basis information that an institution, organization, or individual currently receiving PHS funds or likely to submit a grant or cooperative agreement application or a contract proposal: (1) is under investigation for possible misconduct, or a decision has been made to undertake such an investigation; or (2) has been subjected to a sanction at the conclusion of an investigation for misconduct (e.g., debarment by the Secretary, Department of Health and Human Services (DHHS) from eligibility for research funding, disqualification by the Food and Drug Administration (FDA) from use of investigational drugs, or in the case of scientists employed by the PHS, termination of employment). The information about an organization or individual is used to aid the PHS official in making an informed decision regarding the funds or other PHS benefits to that organization or individual, but such information does not automatically result in a withholding of funds or other benefits.

"Agency" or "funding agency" means each of the PHS agencies as well as the awarding units within the Office of the Assistant Secretary for Health (OASH).

"Component" refers to (1) the organizational units within an agency that have the delegated authority to conduct and/or make awards for scientific activities, e.g., Bureaus, Institutes, Divisions, or Offices, or (2) in the case of the FDA, National Centers or Bureaus.

"Program" is a set of plans and activities for a specific area of scientific or technical subject matter within the mission of a component.

"MPO" means Misconduct Policy Officer, i.e., the official designated to oversee and coordinate PHS, agency, or component implementation of policies related to misconduct in science. Such designation need not entail creation or change in title of a position provided the functions described in this issuance can be appropriately discharged.

## RESPONSIBILITIES

1. Awardee institutions have primary responsibility for preventing, detecting, and dealing with possible misconduct in research programs funded by the PHS. These responsibilities include conducting, supporting, or commissioning investigations as appropriate, as well as informing and cooperating with the awarding agency.
2. The Deputy Director for Extramural Research and Training (DDERT), Office of the Director, NIH, is the PHS MPO. He is responsible for the development, implementation, and assessment of PHS policies related to misconduct in science.
3. The head of each PHS agency will (a) provide leadership to ensure appropriate implementation of policies and procedures for fair and prompt handling of alleged or apparent instances of misconduct in scientific activities currently or previously funded by the agency; (b) decide whether or not interim administrative actions should be taken to protect Federal interests during

investigation of possible misconduct; (c) within the scope of his/her authority, make decisions regarding sanctions that should be applied in cases of confirmed misconduct; and (d) identify an agency MPO.

4. Agency-level MPOs will, in consultation with the responsible offices: (a) coordinate activities with the PHS MPO as appropriate; (b) provide guidance to agency staff regarding these policies and procedures; (c) ensure that inquiries and investigations are conducted in an appropriate and timely manner; (d) coordinate intra- and interagency activities as necessary; (e) determine when a record of individuals and/or institutions under investigation should be established in or removed from the PHS ALERT System, (f) recommend to the agency head interim administrative actions, where appropriate; (g) coordinate follow-up actions to an investigation, and (h) provide guidance to awardee institutions regarding their responsibilities for promoting adherence to high ethical standards in science and otherwise for dealing with instances of possible misconduct.
5. The director of each awarding component will (a) provide the leadership to ensure implementation of these policies and procedures, (b) make recommendations, as appropriate; to the agency head on specific cases, and (c) identify an individual to be the MPO for the component.
6. Component-level MPOs will (a) make available to staff within the component information on policies and procedures related to misconduct; (b) notify, when appropriate, other offices within the agency that need to be informed of possible misconduct; (c) coordinate and/or assist in conducting investigations at the component level, if appropriate; and (d) coordinate follow-up actions to those investigations that are undertaken.
7. Instances of possible misconduct which become known to agency staff must be reported promptly to the MPO of the involved component, who, in turn, will be responsible for informing his/her Component Director and agency-level counterpart.
8. Agency-level MPOs shall decide how instances of possible misconduct will be handled and shall coordinate the necessary activities with the MPO and other relevant staff of the appropriate component.
9. Cases involving possible misuse of federal funds, DHHS internal audits, and investigations by the General Accounting Office or the Office of the Inspector General will be handled by the agency's unit that has jurisdiction over such matters.
10. Investigation of alleged or apparent violations by recipients of PHS research funds of either (a) federal regulations governing the protection of human subjects or (b) PHS animal welfare policy is the responsibility of the Office for Protection from Research Risks (OPRR), NIH. In the case of research that is both funded by the Food and Drug Administration (FDA) and subject to FDA regulation, responsibility for the conduct of individual investigations will be assigned according to mutual agreement between OPRR and the FDA MPO.

11. Matters arising during an inquiry or investigation that (a) involve current or potential litigation or (b) require legal interpretation will be handled by or in consultation with the Office of General Counsel (OGC). OGC should be consulted throughout the inquiry/investigation process to ensure that all potential legal issues have been considered.
12. Matters arising during an inquiry or investigation that involve a potential criminal violation shall be promptly referred to the OIG. Where the OIG or another law enforcement agency is conducting a related investigation into potential criminal violations, that agency must be consulted during the inquiry/investigation into scientific misconduct to ensure proper coordination.
13. After the initial referral to the OIG, the agency-level MPO shall insure that the OIG is consulted in advance in all appropriate instances.
14. The agency-level MPOs will meet bimonthly as a standing committee (the "PHS Committee on Misconduct in Science") under the chairmanship of the PHS MPO. This committee is to ensure (a) mutual consultation on, and review of, policy issues of common interest, (b) sharing of information relevant to more than one agency, and (c) collaboration on joint investigations, when warranted. The Committee will refine PHS-wide policies and procedures, as necessary, and promptly apprise relevant agency staff and awardees of changes once they have been approved by the Assistant Secretary for Health (ASH).
15. Inquiries from the communications media will be coordinated by a designated office in each agency and referred to the agency-level MPO, as appropriate. Press releases related to misconduct in science must be cleared by the agency's public affairs office, the Office of Assistant Secretary for Health and the Office of the Secretary.

#### POLICY

1. The MPOs throughout the PHS will make a continuing effort to inform agency staff, scientific review groups, national advisory councils/boards (or equivalents) and the scientific community of the policies and procedures defined in this document and to emphasize the importance placed on this matter by PHS.
2. All agency actions taken in response to instances of of alleged or apparent misconduct will take into consideration (a) safeguards for the affected parties—e.g., confidential treatment, prompt and thorough inquiry and/or investigation, and opportunity to comment on all allegations and/or findings; (b) the rights of informants—e.g., protection of their privacy and (c) the need to ensure that the interests of the Government are protected.
3. As a general rule the awardee and/or employer institution should initiate its own inquiry into an instance of possible misconduct and conduct a subsequent investigation, if warranted, unless the possibility of a criminal violation suggests that early notification of the OIG is warranted. Such notification may be made through the funding agency.

4. When a PHS agency decides to initiate an investigation, the individuals and/or institutions that are to be the subjects shall be notified of that fact before the investigation commences, unless a law enforcement agency conducting a related investigation requests otherwise. This notification should include information on the nature of the allegations or concerns and the focus of the investigation. The recipients of the notification will also be informed of the opportunity to provide comments and other relevant information to the funding agency, and if criminal charges are involved, the OIG, or other law enforcement agencies.
5. Interim administrative actions may be necessary prior to completion of an investigation to safeguard the integrity of the project involved, prevent inappropriate use of Federal funds, or otherwise protect the interests of the funding agency and the public.
6. As a general rule, allegations or information developed in the course of an ongoing investigation will be made available only to the PHS MPO, the appropriate agency-level MPO, agencies conducting related investigations, and individuals who (a) are involved in or associated with the actual conduct of an investigation; or (b) have direct responsibility for an ongoing or pending award. The agency-level MPO will immediately inform his/her counterparts in the other agencies if: (a) it appears that they have an active or pending award that might be affected; (b) it might have a bearing on a decision to appoint an individual as an advisor, consultant, or reviewer; or (c) the information is relevant to the regulatory responsibilities of another agency. As provided in the PHS ALERT for Misconduct in Science, the bimonthly meetings of the PHS Committee on Misconduct in Science will include a brief review of pending investigations to ensure that all relevant agency concerns are addressed.
7. Review of grant/cooperative agreement applications and contract proposals for scientific merit will not ordinarily be delayed by concerns about possible misconduct or by a pending or ongoing investigation. To avoid influencing the review process, PHS awarding units generally will not inform members of scientific review groups about instances of possible misconduct or the status of ongoing investigations. However, if certain instances have received such extensive publicity that the review may be compromised, the agency-level MPO may recommend that officials responsible for review defer the review or inform the reviewers of the status of the agency's activities with regard to the possible misconduct. By contrast, findings from completed investigations should be shared with scientific review groups whenever the information bears directly upon the investigator's scientific or fiscal integrity or disclosure is necessary to provide an accurate account of the facts in the case.
8. Directors of awarding components are to consult with and seek the advice of their national advisory councils/boards (or equivalents) on a potential competing grant or cooperative agreement award to an individual or institution under investigation by the awardee institution, the funding agency, or another entity (when such disclosure is otherwise permissible). When a non-competing award is involved, the agency-level MPO should be consulted.

9. The agency-level MPO, in consultation with the appropriate offices, will determine if a record of the subject(s) of investigation is to be created in the ALERT system and, if so, will implement such a decision through the Director, Division of Management Survey and Review (DMSR), NIH. (See PHS ALERT for Misconduct in Science for further details.)
10. The agency-level MPO shall ensure that every reasonable effort is made to allow the subject(s) of an ongoing or completed investigation to provide comments, rebuttals and other related information for consideration by the investigating agency.
11. In responding to any request(s) from a non-DHHS source for information about ongoing investigations, agency staff shall maintain the confidentiality of such information to the greatest extent possible under the provisions of the Freedom of Information Act, the Privacy Act, and other applicable law. To the extent permitted by law, agency personnel will protect the identity, if desired by the subject, of any person who is the subject of an inquiry that is terminated without triggering an investigation, or any person on whom an investigation fails to confirm misconduct. To the extent permitted by law, it is PHS policy to protect the identities, if desired by the persons affected, of those who in good faith report apparent misconduct or furnish information about such apparent misconduct.
12. If the investigation does not establish misconduct, the funding agency responsible for the investigation shall promptly notify all concerned parties in writing.
13. Upon completion of an investigation that confirms misconduct, the funding agency shall take steps to initiate or impose appropriate sanctions.
14. When sanctions are imposed upon recipients of PHS financial assistance or contracts, the head of the PHS awarding component shall ensure that the notification is provided as required under the HHS Alert System. (See PHS Grants Administration Manual Chapter i:1-06.)

## PROCEDURES

### Reporting of Possible Misconduct

1. The PHS MPO shall maintain and update, as necessary, a list of the names of individuals who have been appointed as agency-level MPOs.
2. Each agency-level MPO shall maintain and update periodically a list of the names of individuals who have been appointed as MPOs at each level within the agency.
3. Staff who receive a report or suspect an instance of possible misconduct shall promptly and discreetly inform the MPO at the awarding component level who will then notify the agency-level MPO and the director of the awarding component.

4. To the extent possible, the identity of informants who do not wish to be generally known will be kept confidential.
5. The awarding component's MPO should document whatever information he/she receives regarding an instance of possible misconduct. If appropriate, he/she should request additional information from the awardee institution.
6. The agency MPO, in consultation with other offices as appropriate, shall review the allegation for the purpose of determining if there is a possibility of criminal misconduct. If the possibility exists, the agency MPO shall ensure that the matter is referred through appropriate channels to the OIG and shall coordinate efforts if a related investigation is initiated.

#### INQUIRIES

1. The unit in whose jurisdiction the case falls—e.g., OPRR, DMSR, or the awarding component—shall promptly initiate an inquiry to determine whether an investigation is warranted. As a general rule, no more than 60 days should elapse between the reporting of an instance of possible misconduct and the completion of an inquiry.
2. The agency-level MPO shall direct that a search of its record system(s) be made to identify other ongoing or pending awards so that (a) if appropriate, other awarding components within the agency, including review staff, may be informed and (b) the potential effects of any misconduct on the institution's or investigator's eligibility for current or future awards are duly considered.
3. The agency-level MPO, in consultation with (a) the director of the agency's unit that has authority for investigating the type of possible misconduct reported, (b) the MPO in the awarding component, and (c) the director of the awarding component shall decide whether a formal investigation is warranted. These determinations, to be made on a case-by-case basis, require an assessment of the following factors:
  - a. the accuracy and reliability of the source of information about the possible misconduct;
  - b. the seriousness of the possible misconduct;
  - c. the scope of the incident(s) and the context in which it (they) became known;
  - d. explanations, if any, that are provided by the subject(s) of the inquiry; and
  - e. other information developed during the inquiry.

#### INVESTIGATIONS

1. When an awardee institution has promptly initiated an investigation, the funding agency may defer its own fact-finding activities until it has received the results of the institutional investigation. If at the end of 120 days the institutional

investigation is not making satisfactory progress and if it offers little prospect of an expeditious conclusion, then the agency should proceed with its own investigation. In an instance in which the funding agency decides to defer its own fact-finding activities, such decision should be documented by the agency-level MPO.

2. If the matter involves a concurrent investigation of scientific and criminal allegations conducted by the Department of Justice, the Federal Bureau of Investigation or the Office of the Inspector General without the knowledge of the individual or institution, OGC or the agency's unit in whose jurisdiction the case falls will notify both the awarding component's MPO and its director as to what information, if any, may be disclosed to the subject(s) of the investigation. Disclosure should be made only after consultation with the OIG and other appropriate law enforcement offices.
3. When the agency decides to initiate an investigation, individuals and/or institutions that are to be investigated must be notified immediately in writing by the agency-level MPO or his/her designee.
4. The agency-level MPO shall take appropriate steps to establish a record of individuals and organizations under investigation in the PHS ALERT as provided in "Public Health Service ALERT for Misconduct in Science."
5. The methods and procedures for conducting an investigation will necessarily vary depending on a number of factors, including: (a) the nature of the allegation/evidence; (b) the source(s) of information; (c) the extent to which a current award(s) may be involved; (d) whether an awardee institution has already conducted and documented its own investigation, and the extent to which documentation is available; and (e) the degree of publicity associated with the case; and (f) the involvement of law enforcement agencies.
6. An investigation may consist of a combination of activities such as, but not limited to:
  - a. review of readily available documents that the agency has already received from the individual and/or institution, e.g., grant or contract files, reports and other documents;
  - b. review of documents at the awardee institution or elsewhere;
  - c. review of administrative procedures and/or methods at the awardee institution, including whatever investigative process the institution followed in dealing with the instance at hand;
  - d. inspection of laboratory or clinical facilities and/or materials at the awardee institution; and/or
  - e. interviewing of parties with an involvement in or knowledge about the case.

7. In any given case, the agency-level MPO shall be responsible for ensuring that appropriate consultation takes place among representatives of the involved awarding component(s), OGC, the agency unit responsible for investigating the case, and review staff. Investigations falling clearly within the jurisdiction of a particular office (e.g., OPRR, DMSR) may be coordinated by that office provided the agency-level MPO is informed of progress and any problems that may arise.
8. If outside consultants are to be invited to participate in an investigation, either as site visitors to the awardee institution or in some other capacity, they must be appointed in a manner that ensures the official nature of their involvement and provides them with such legal protections as are available to federal employees.

#### INTERIM ADMINISTRATIVE ACTIONS

1. Prior to completion of an investigation by either the funding agency or the awardee institution, the agency-level MPO may recommend to the director of the awarding component that interim administrative actions be taken to protect the welfare of human or animal subjects of research, prevent inappropriate use of federal funds, or otherwise protect the public interest. This recommendation shall be made only after consultation with:
  - a. the MPO of the awarding component;
  - b. OGC;
  - c. the unit of the agency responsible for investigating the case; and
  - d. a senior grants or contract management official.

Interim actions affecting more than one awarding component should be brought to the attention of the agency head.

If an investigation is being conducted by a law enforcement agency or the OIG, the agency MPO should (1) consult with OGC before recommending any action that might disclose or otherwise compromise the investigation and (2) consult with the OIG prior to implementing any administrative actions.

2. The following principles should guide the selection of an interim administrative action:
  - a. Interim actions should be taken only after it has been determined that a formal investigation is warranted. The decision to undertake an investigation is a necessary, but not always sufficient, condition for taking an interim action.
  - b. Any interim restriction should be taken with a view toward protecting the rights of all involved parties and minimizing disruption to the project, the institution, and the activities of those involved in the project.

- c. Interim action should be taken promptly when (1) there is evidence of a serious failure to comply with the requirements for the protection of human or animal subjects, or (2) the welfare of such subjects of research is or has been jeopardized.
  - d. An interim action may be taken when additional information developed during the course of an investigation indicates the need for such action. Similarly, temporary restrictions that have been imposed should be reviewed periodically and modified, if warranted by additional facts or findings.
3. Interim administrative actions may include, but are not limited to, the following:
- a. total or partial suspension of an award;
  - b. total or partial suspension of eligibility for financial assistance (grants or cooperative agreements) in accordance with DHHS debarment regulations (45 CFR 76) and for contracts in accordance with applicable regulations (48 CFR Subpart 9.4; (48 CFR 309.4; 50 Federal Register 7780, February 26, 1985).
  - c. proscription or restriction of certain research activities, e.g., restrictions to protect any human or animal subjects of research whose welfare may be in jeopardy;
  - d. requirement for special certification, assurances or other administrative arrangements to ensure that specific activities are carried out in compliance with applicable regulations or terms of the award;
  - e. more restrictive requirements for prior approval;
  - f. deferral of a noncompeting continuation grant or cooperative agreement;
  - g. deferral of a competing grant or cooperative agreement;
  - h. delaying a contract award; and
  - i. restriction or suspension of the use of individuals under investigation as advisors or consultants to the agency.
4. All interim administrative actions that are taken, and the reasons for taking them, must be fully and promptly recorded in the investigative files. Information recorded in the grant or contract files shall be limited to the minimum necessary to implement the action(s).
5. Certain interim administrative actions under 3.a. through h. above shall also be reported to the Director, DGC/OASH, for possible inclusion in the HHS Alert System. Interim actions that should be communicated to OASH include those having PHS-wide or DHHS-wide implications, e.g., suspension of an award or recommendation that an individual or institution be suspended from eligibility for funding. Such actions, while they may be taken prior to the conclusion of an investigation, include procedural safeguards for the protection of individual

rights and institutional interests. Actions whose scope is limited to a single agency's transactions, e.g., restrictions on appointments to advisory committees or imposition of special terms or conditions on an award, are ordinarily not appropriate for disclosure to PHS staff who do not have a clear need to know of them.

#### POST-INVESTIGATIONAL ACTIONS

1. Upon completion of an agency investigation, the investigative team shall prepare a written report summarizing its findings. This report shall be reviewed by the agency-level MPO and the director of the awarding component.
2. If there is an ongoing related law enforcement investigation, the agency-level MPO shall obtain the OIG concurrence prior to releasing the report to the subject.
3. As a general rule, every reasonable effort should be made to complete an investigation and the report of findings within 120 days of completion of the preceding inquiry. This time frame will, however, depend heavily on such factors as whether or not the instance of possible misconduct was an isolated event or part of a repeated pattern, whether the subject has already admitted culpability or disputes the allegations or other information suggesting his/her culpability, and other circumstances that may require time-consuming pursuit of facts. If an investigation and the attendant report of findings cannot be completed in 120 days, an interim report on progress to date and an estimated schedule for completion of the final report must be prepared and submitted to the agency-level MPO at the end of 90 days. Thereafter a status report must be submitted every 60 days until such time that the report of investigative findings is completed.

When investigative findings fail to confirm an instance of misconduct and the agency-level MPO concurs with such findings, the following procedures shall apply:

- A. The subject(s) of the investigation, his/her immediate supervisor and, if appropriate, the individual or institutional official who reported the possible misconduct, will be notified in writing. This notification, which may include the report of findings from the investigation, will be sent by:
  - (1) the unit of the agency responsible for conducting the investigation; or
  - (2) OPRR, if the case involved possible violations of either federal regulations governing the protection of human subjects or PHS animal welfare policy; or
  - (3) the agency-level MPO, if the case did not fall in the jurisdiction of the units identified in (1) or (2) above.
- B. A copy of the above notification should also be provided to:
  - (1) the agency-level MPO (if the latter is not the party responsible for sending the notification);

- (2) the director of the awarding component;
- (3) the awarding component's MPO; and
- (4) members of the investigative team, if any, who are drawn from outside the investigative unit.

- C. The agency-level MPO will assure the lifting of whatever interim administrative restrictions may have been imposed.
- D. If a record of the subject(s) of investigation has been created in the ALERT system, the agency-level MPO will direct the removal of the names of the affected individual(s) or organizations(s).
- E. If a competing application or proposal is pending or anticipated in the near future, the agency-level MPO will consult with officials responsible for review in order to identify and resolve any concerns that might affect the objectivity of the review, e.g., informing the Executive Secretary and reviewers of the outcome. Such action should only be taken if there is reason to believe that reviewers have received incomplete or misleading information about the case.

When investigative findings confirm misconduct and the agency-level MPO concurs with such findings, the following procedures shall apply:

- A. The agency MPO will, except in unusual circumstances, provide a copy of the report to the individual(s), his/her immediate supervisor, and/or institution(s) under investigation. As a general rule, the subject(s) of the investigation shall be allowed no more than 30 days to provide comments or rebuttal.
- B. All responses submitted by the subject(s) of the investigation shall receive full consideration and, where appropriate, may lead to revision or expansion of the report before it is forwarded for action to the agency head. Such comments will be appended to the report unless it is determined that such action would constitute an unwarranted invasion of an individual's privacy.
- C. In a case in which the report of investigative findings is prepared by the awardee institution, the funding agency must take certain actions to assess the accuracy, thoroughness and acceptability of the report. These actions may include (i) seeking the comments/rebuttal of the subject(s) of the investigation in instances in which the institution has failed to do so, and (ii) conducting a review of the institution's investigation in instances in which there is insufficient documentation of adequate procedures, scope or thoroughness in the investigation. Upon completion of this process, which generally may take up to 30 days, the agency shall either accept the institution's report or initiate its own investigation.
- D. When an investigative report is determined to be complete and accurate, the agency-level MPO will arrange for a systematic review of the investigative findings and all relevant documents, including comments and rebuttals, if any,

from the subject(s) of the investigation, to determine what sanctions should be recommended to the agency head. (A listing of possible sanctions is given below.) As a general rule, this process, including the preparation of the decision document for the agency head, shall be completed within 30 days.

- E. Participants in the effort to review the investigative report and recommend sanctions shall include at least the following:
- (1) the agency-level MPO;
  - (2) the director(s) of the awarding component(s) currently funding an award or considering a pending award;
  - (3) the awarding component's MPO;
  - (4) the director(s) of the affected program(s) within the involved awarding component(s);
  - (5) senior agency-level grant or contract policy staff;
  - (6) a representative of OGC; and
  - (7) at least one senior agency official with no direct involvement in the case.
- F. Agency staff members who have conducted the investigation may be invited, as appropriate, to serve as resources to the group identified in E above.
- G. When the investigative report has been compiled by the OIG, that office may be invited to participate. If a related law enforcement investigation is underway, the OIG should be consulted prior to transmitting recommendations to the agency head.
- H. The following factors should be considered in deciding which sanctions are appropriate in a given case:
- (1) need for reasonable consistency in the application of sanctions, i.e., violations of the same type or degree deserve the same kind of sanction(s);
  - (2) the nature of the misconduct, i.e., was the violation deliberate, the result of carelessness, or was it caused by factors that might not have been reasonably foreseen or controlled?
  - (3) whether the incident of misconduct was an isolated event or part of a pattern;
  - (4) the degree of seriousness or gravity of the violation (e.g., were data fabricated or falsified? was human life jeopardized? were animals abused?)

- (5) whether the nature of the misconduct is relevant only to certain funding requests/awards or whether it is germane to all requests from or awards to the institution or individual(s) found culpable of misconduct.
- H. The agency head shall review the recommendations of the group identified in E above. If he/she elects to recommend debarment, he/she must apprise the appropriate higher level official promptly and in writing; subsequent communications with the affected individual(s) or institution(s) shall be in accord with the applicable regulations. Otherwise, the agency head within 30 days, as a general rule, shall communicate his/her decisions in writing to the affected investigator(s) and/or institution(s).
- I. Any sanctions imposed by the agency head shall be communicated in writing to the Director, DGC/OASH for inclusion in the HHS Alert System.
- J. The PHS ALERT may be used to implement post-investigational sanctions. Information retained in the official grant or contract file shall be limited to the minimum necessary to implement the action(s) in order to avoid unintended damage to individual reputations or prospects for funding.

#### SHARING OF AGENCY FINDINGS OF MISCONDUCT

The following options are available to the PHS MPO and the agency-level MPOs for application in appropriate circumstances. These options are reserved for cases of confirmed misconduct in which the seriousness of the misconduct-- e.g., widespread dissemination of fabricated research findings or the abuse of human research subjects or laboratory animals--necessitate sharing of information about the affected individual(s) and/or institution(s) with other federal or non-federal groups and/or organizations. These options should not be considered as mandatory actions but rather as potential actions that might be taken by a PHS agency.

1. The PHS MPO may share investigational findings - including associated commentaries/ rebuttals from the affected individual(s), department(s) and/or institution(s) - with other PHS agencies, federal agencies outside the PHS, and non-federal agencies or organizations.
2. The agency-level MPO may share, for a specified period of time, investigative findings - including associated commentaries/rebuttals from the affected individual(s), department(s) and/or institution(s) - with scientific review groups and national advisory councils/boards (or equivalents) when they consider requests for further funding from those individual(s), department(s), and/or institution(s).

#### SANCTIONS

The sanctions listed below, provided here for guidance, are classified by degree of severity, ranging from those which constitute minimal restrictions (Group I) to those that are the harshest and most extreme (Group III). They do not include possible criminal

sanctions which may be applicable in some cases. Any of these sanctions may also involve recovery of funds if such action is warranted by the investigative findings and is otherwise appropriate to the funding instrument.

#### GROUP I SANCTIONS

- o Send a letter of reprimand for improper action to the individual and/or institution.
- o Require, for a specified period of time, that an individual, department, and/or institution obtain from the funding agency special prior approval of particular activities as a condition of award.
- o Require, for a specified period of time, that an institutional official other than the individual found culpable of misconduct certify the accuracy of reports generated under an award and/or provide assurance of compliance with particular policies, regulations, guidelines, or special terms and conditions.

#### GROUP II SANCTIONS

- o Restrict, for a specified period of time, specific activities or expenditures under an active award(s).
- o Require, for a specified period of time, that the concerned national advisory council(s)/board(s) (or equivalents) conduct a special review of all awards to the affected individual, department, and/or institution to determine whether funding should be continued.
- o Require, for a specified period of time, special reviews of all requests for funding from the affected individual and/or institution to ensure that the every reasonable step has been taken to prevent repetition of the misconduct.
- o Prohibit participation of affected individuals on peer review committees, advisory groups or in other related PHS activities for a specified period of time.

#### GROUP III SANCTIONS

- o Immediately suspend/terminate an active award(s).
- o Withhold funding of specific future non-competing grants or contracts.
- o Debar or suspend the individual, department, and/or institution for a specified period of time, declaring them ineligible for any participation in PHS grants,

cooperative agreements or contracts. (This action may be taken only by the Deputy Assistant Secretary for Procurement, Assistance, and Logistics, OS.

#### PROTECTION OF RECORDS FROM RELEASE UNDER THE FOIA

1. An investigation will be considered to be pending and prospective, or active and ongoing, and therefore all records will be withheld to the extent allowed by the FOIA, until one of the following events occurs:
  - a. In the event the investigative findings fail to confirm misconduct: When the subject(s) of the investigation are notified in writing of that decision.
  - b. In the event the investigative findings confirm misconduct: When the agency head communicates his/her decision in writing to the affected investigator(s) and/or institution(s), or when the appropriate DHHS official makes a decision on a recommended debarment or suspension.
2. The records of a closed misconduct investigation are normally releasable unless the disclosure would constitute an unwarranted invasion of personal privacy or impede an on-going related investigation, or if it is otherwise decided to invoke one of the exemptions to the disclosure mandate of the FOIA.

#### AWARDEE RESPONSIBILITIES\*

1. Efforts should be made by awardee institutions on an ongoing basis to inform their scientific staff of policies and procedures for dealing with instances of alleged or apparent misconduct in science and to emphasize the importance placed on this subject matter by both the institution and the PHS.
2. The primary responsibility for prevention of misconduct in association with PHS-funded research rests with the awardee institutions. The PHS supports institutional adherence to the principles and guidelines stated in the June 24, 1982 report of the Association of American Medical Colleges Ad Hoc Committee on the Maintenance of High Ethical Standards in the Conduct of Research and the report of the Committee on Integrity of Research of the Association of American Universities.
3. Officials and scientific staff of organizations applying for or receiving funds from the PHS have a responsibility to take immediate and appropriate action as soon as misconduct on the part of employees of their organization is known, suspected or alleged.

\* This section will be published separately for comment as a notice of proposed rulemaking.

4. Awardee institutions should adopt policies and procedures that, at a minimum, provide for:
- (a) conducting an inquiry immediately into any allegation or other evidence of misconduct;
  - (b) protecting the privacy of those who in good faith report apparent misconduct;
  - (c) affording the affected individual(s) confidential treatment, a prompt and thorough investigation (if warranted), and an opportunity to comment on allegations and/or findings;
  - (d) notifying the awarding component immediately if findings from the inquiry indicate that an investigation is indicated;
  - (e) in instances in which institutional officials determine, on the basis of their inquiry, that it is not necessary to undertake an investigation, documenting the reasons for the decision and the findings from their inquiry (if the funding agency subsequently becomes aware of the case and believes it to be sufficiently substantive, the agency will proceed with its own investigation);
  - (f) undertaking an investigation if findings from the inquiry provide sufficient basis for doing so; in carrying out investigations, awardee institutions should act promptly, ensure fairness to all, secure necessary and appropriate expertise to carry out a thorough and authoritative evaluation of the relevant evidence, and take precautions against real or apparent conflicts of interest;
  - (g) taking interim administrative actions, as appropriate;
  - (h) keeping the funding agency apprised of any developments during the course of the investigation which disclose facts that may affect current or potential PHS funding for the individual(s) under investigation or that the funding agency needs to know to ensure appropriate use of federal funds and otherwise protect the public interest;
  - (i) if the possible misconduct is not substantiated, undertaking diligent efforts, where appropriate, to restore the reputation of those under investigation;
  - (j) if misconduct is confirmed, imposing appropriate sanctions (awardee institutions should recognize that the funding agency may impose sanctions of its own); and
  - (k) notifying the awarding component of the final outcome.
5. Allegations or other indications of misconduct in PHS-funded research must be reported to the director of the program in the awarding component except when an institution's inquiry indicates that there is no basis for an investigation.

Upon receipt of such reports of possible misconduct, the program director shall then notify the awarding component's MPO who will be responsible for informing his/her agency-level counterpart.

6. There may be instances where the awarding component should be notified by the awardee institution even prior to the latter's decision to initiate an investigation. The following factors should be considered in deciding when to notify the awarding component:
  - a. the seriousness of the possible misconduct;
  - b. whether a situation of immediate health hazards is involved;
  - c. the need to protect the interests of the funding agency;
  - d. the need to protect the interests of the individual who is the subject of the impending investigation as well as his/her co-investigators and associates, if any;
  - e. the institution's responsibility to the scientific community and the public at large;
  - f. whether there are allegations of criminal violation.
7. As a general rule, the institution is encouraged to take no more than 30 days to conduct its inquiry and determine whether an investigation is warranted. If the inquiry cannot be completed within 30 days, the institution must notify the agency immediately, provide the reasons for the delay and indicate when the inquiry would be completed. If an investigation is to be undertaken, the institution shall generally take no more than 120 days to complete the investigation, prepare the report of findings, obtain the comments of the subject(s) of the investigation, and make a decision on the disposition of the case. If the institution determines, at the end of 90 days, that it cannot complete its investigation and related activities within the 120-day period, it must submit to the agency an interim report on progress to date and an estimated timetable for completion of the necessary activities. Thereafter a report must be submitted every 60 days until such time that the investigation and all attendant actions are completed.

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**association of american  
medical colleges**

CLINICIAN-EDUCATOR FACULTY TRACKS  
IN U.S. MEDICAL SCHOOLS

*Robert F. Jones, Ph.D.*

*September, 1986*

DEPARTMENT OF INSTITUTIONAL DEVELOPMENT

## CLINICIAN-EDUCATOR FACULTY TRACKS IN U.S. MEDICAL SCHOOLS

As the medical service component of academic medical centers has grown over the past two decades, medical schools have had to modify their faculty appointment policies and procedures to recruit and retain the physician faculty necessary to fulfill their expanded patient care missions. One change has been the emergence of clinician-educator faculty tracks. The clinician-educator faculty track in medical schools may take on different forms and titles and accord to faculty in the track different rights, privileges, and responsibilities. It is defined here as a formal, full-time, non-tenure earning appointment track for M.D. faculty members who are primarily engaged in patient care and teaching. While evidence of scholarly activity is required for promotion of faculty in this track, expectations regarding research publications are generally less than for tenure-track faculty. This report presents the results of a study to determine the frequency of clinician-educator faculty tracks in U.S. medical schools, the titles given to faculty members in the track, and special features of interest.

### Sources of Information

A first source of information consulted for this report was the 1983 AAMC Survey of Faculty Appointment Policies and Procedures. Respondents to the survey who did not specifically

indicate the presence of the track as well as non-respondents were followed up by telephone survey in the early months of 1986. This produced a 100 percent response rate of medical schools with tenure systems and provided up-to-date information on schools which had recently instituted a clinician-educator track.

### Results

A clinician-educator faculty track, as defined in this report, can exist only in the context of a tenure system. Of 126 accredited U.S. medical schools (excluding the two year program at the University of Minnesota-Duluth), eight do not have a tenure system while another six schools have a tenure system for basic sciences faculty only. Of the remaining 112 schools, 61 (55 percent) were identified as having in place a non-tenure earning clinical faculty track that met the requirements stated previously. These schools are listed with descriptive information in the Appendix. Of the 51 schools not identified by the presence of a clinician-educator track, 16 specifically indicated in telephone follow-up that the institution of such a track was actively being considered.

Twenty-three percent (14) of the schools with a clinician-educator track do not modify or qualify the title of faculty members in the track, except on official school records (Table 1). The majority of schools, however, modify the faculty title either by prefixing the term "clinical" to the designation of specialty or department (19 schools, 31 percent) or prefixing it to the rank (15 schools, 25 percent). In most cases, the latter title fails to distinguish the full-time faculty in this

TABLE 1  
 TITLES USED TO DESIGNATE CLINICIAN-EDUCATOR FACULTY  
 IN U.S. MEDICAL SCHOOLS

<u>Title</u>	<u>Number of Schools</u>	<u>Percentage of Schools</u>
1. Unmodified	14	23
2. Clinical prefix to specialty (e.g., associate professor of clinical surgery)	19	31
3. Clinical prefix to rank (e.g., clinical associate professor of surgery)	15	25
4. Location specified (e.g., associate professor of surgery at Mercy Hospital)	2	3
5. Other	7	11
6. Titles 1 and 2	1	2
7. Titles 2 and 3	3	5
Total	61	100

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track from part-time or volunteer faculty at the school. At four schools (7 percent), non-tenured clinician-educator faculty can be designated by different titles, depending on the extent to which research activities are expected. Two schools (3 percent) modify the faculty title by specifying the site of patient care and teaching activity, while another 7 schools (11 percent) provide modified titles unique to their institutions.

### Conclusion

While 51 medical schools with tenure systems do not have a formal clinician-educator track as defined here, it cannot be assumed that they all have no provision for retaining skilled clinicians and teachers who fail to meet the traditional research requirements for tenure. Four schools have effectively eliminated the concept of faculty tracks while continuing to confer tenure. Another 24 schools have provisions for continuing the appointment of faculty members denied tenure after the stated probationary period. Often a distinction is made between non-tenure appointments and a non-tenure faculty track. Of the remaining 23 medical schools, without a clinician-educator track as defined here and with a traditional "up or out" tenure system for clinical faculty, 10 are known to be among those discussing the institution of such a track. A further alternative introduced or proposed is the modification of tenure criteria to give greater prominence to clinical service and teaching contributions. Each of these represent different solutions to the problem academic medical centers face in recruiting and

retaining clinical faculty members who are key to preserving the patient base for teaching and research.

APPENDIX

MEDICAL SCHOOLS WITH A NON-TENURED FACULTY TRACK  
FOR CLINICIAN-EDUCATORS

<u>School</u>	<u>Titles</u>	<u>Notes</u>
University of South Alabama	1	Annual contracts
University of Arizona	3	Annual contracts
University of Southern California	2	Annual contracts
Stanford University	5	Multi-year and indefinite service appointments; title is modified by the suffix "(clinical)"
University of California - Irvine	3	Annual contracts; title same for part-time/volunteer
University of California - Davis	3	Multi-year contracts; official documents distinguish full- time from voluntary by the suffix "(compensated)"
University of California - San Diego	3	Annual and multi-year contracts
University of California - San Francisco	3	Multi-year contracts

Titles:

- 1 - Unmodified
- 2 - Clinical prefix to specialty, e.g., associate professor of  
clinical surgery
- 3 - Clinical prefix to rank, e.g., clinical associate professor  
of surgery, associate clinical professor of surgery, or  
associate clinical professor
- 4 - Location specified, e.g., ~~associate professor of surgery at~~  
Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
Yale University	1	Appointment "without term" but not tenured; differentiation of tracks starts at associate professor level; official documents indicate "in clinical track"
Georgetown University School of Medicine	4	Annual contracts; track established for medical and dental schools
George Washington	1	Annual appointment
University of Miami	2	Annual contracts
Mercer University	1	Annual letter of appointment
Emory University	5	Title is suffixed by "clinical track"
Chicago Medical School	5	Title is modified by suffix "affiliate"; multi-year contracts; title same for volunteer
Loyola-Stritch School of Medicine	1/2	Annual contracts; titles #1 and #2 can be given to tenure- and non-tenure track faculty; the non-tenure track is a generic track which includes faculty in the category of clinician-educators
Northwestern University	2	Annual and multi-year appointments; title same for volunteer

Titles:

- 1 - Unmodified
- 2 - Clinical prefix to specialty, e.g., associate professor of clinical surgery
- 3 - Clinical prefix to rank, e.g., clinical associate professor of surgery, associate clinical professor of surgery, or associate clinical professor
- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
University of Chicago	2/3	Titles #2 and #3 differ in terms of research expectations; faculty with title #2 can work toward an appointment "without term"
Southern Illinois University	2	Annual appointment letter
University of Illinois	3	Annual contracts; title same for volunteer
University of Kentucky	3	Annual contract; full-time versus volunteer faculty only distinguished on official records
Louisiana State University - Shreveport	2	Continuing appointment
Louisiana State University - New Orleans	2	Annual contracts
Tulane University	2	Annual contracts; track established for medical school and law school
University of Maryland	5	Title is modified by a prefix "medical school" to rank; annual and multi-year contracts
University of Massachusetts Medical School	1	Annual and multi-year contracts
University of Michigan	3	Letter of appointment, title same for part-time/volunteer

Titles:

- 1 - Unmodified
- 2 - Clinical prefix to specialty, e.g., associate professor of clinical surgery
- 3 - Clinical prefix to rank, e.g., clinical associate professor of surgery, associate clinical professor of surgery, or associate clinical professor
- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
Dartmouth Medical School	2	Annual and multi-year contracts
Wayne State University	1	Annual contracts; in official documents, title is suffixed by "(clinical)"
St. Louis University School of Medicine	1	Official school documents indicate the track by an "*" after title
University of Nevada	1	Annual contracts; in official records designated by "(clinical compensated)"
UMDNJ - New Jersey Medical School	2	Multi-year contracts
UMDNJ - Rutgers Medical School	2	Multi-year contracts
Albany Medical College	2/3	Annual contracts; title #2 can be given to tenure and non-tenure track faculty; title #3 is exclusively non-tenure track. Differences in titles relate to expectations regarding research which for title #2 are less than an unmodified title but greater than title #3
Columbia	2/3	Annual contracts; title #2 has less research expectations than unmodified title (tenure track) but greater than title #3

Titles:

- 1 - Unmodified
- 2 - Clinical prefix to specialty, e.g., associate professor of clinical surgery
- 3 - Clinical prefix to rank, e.g., clinical associate professor of surgery, ~~associate clinical professor of surgery, or~~ associate clinical professor
- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
Cornell University Medical College	2	Faculty at primary teaching hospital are reviewed and granted "tenure of title" or given a non-renewable contract; other faculty given renewable annual appointment
Mount Sinai	2	Open-ended letter of appointment
University of Rochester	2	Annual and multi-year contracts
SUNY - Downstate Medical Center	3	Annual and multi-year contracts; title same for part-time/volunteer
SUNY - Stony Brook	3	Annual and multi-year contracts; title same for volunteer
University of North Carolina	3	Multi-year contracts; title same for volunteer
Duke University	3	Annual contracts; title same for volunteer
University of North Dakota	1	Annual contracts
Case Western Reserve University	1	Annual letter of appointment
Ohio State University	2	Annual contracts; major review at five year intervals

Titles:

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- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
University of Cincinnati	2	Annual and multi-year letter of appointment
Oral Roberts	1	Annual contracts
University of Pennsylvania	4	Multi-year contracts at assistant professor level; at higher level, continuing appointment subject to termination in accord with established due process procedures
University of Pittsburgh	3	Annual and multi-year contracts; title does not distinguish full-time vs. volunteer
University of South Carolina	3	Annual or open-ended contracts; title does not distinguish full-time vs. volunteer; clinical prefix is generally dropped in internal communications, used only on official appointment letter or contract
University of Texas - Houston	1	Annual contracts
University of Texas - Galveston	3	Annual contracts; volunteer faculty titles include only clinical prefix and rank, not "of _____."
University of Texas - Southwestern	2	Annual contracts

Titles:

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- 3 - Clinical prefix to rank, e.g., clinical associate professor of surgery, associate clinical professor of surgery, or associate clinical professor \_\_\_\_\_
- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

<u>School</u>	<u>Titles</u>	<u>Notes</u>
University of Texas - San Antonio	2	Annual contracts
Texas Tech University	2	Annual appointment
University of Utah	5	Annual contracts; title modified by "(clinical)" suffix to rank
University of Vermont	1	Two-year contracts
Medical College of Virginia	1	Annual and multi-year contracts
West Virginia University	5	Annual contract; newly instituted track, title being developed
University of Wisconsin	5	Title is modified by the suffix "(CHS)," which stands for clinical health sciences, multi-year contracts; faculty in this track are peer-reviewed (analogous to tenured faculty) in their eighth year, resulting in termination after ninth year or continued appointment but still without tenure
Medical College of Wisconsin	2	Annual and multi-year contracts

Titles:

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- 3 - Clinical prefix to rank, e.g., clinical associate professor of surgery, associate clinical professor of surgery, or associate clinical professor
- 4 - Location specified, e.g., associate professor of surgery at Mercy Hospital
- 5 - Other

## MODEL FEDERAL POLICY FOR PROTECTION OF HUMAN SUBJECTS

On June 3, 1986, the Office of Science and Technology Policy (OSTP) published in the Federal Register a proposed model federal policy for the protection of human research subjects. The policy is expected to be adopted by all federal agencies involved in the support, conduct or regulation of research involving human subjects. The model policy's development was stimulated by the First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research released in December 1981. The adoption of a single model policy for all federal agencies was the most important of the nine Commission recommendations.

The model policy was based on existing DHHS regulations governing research involving humans. The DHHS regulations have been successfully implemented and shown to be workable in a variety of local conditions. By using these existing procedures, the reservoir of experience was tapped and at the same time, the administrative burden of complying with the sometimes conflicting regulations of several agencies was addressed. There were several modifications and rephrasing changes made to the HHS regulations to make them appropriate for the model policy, which did not seem to substantially alter current NIH policy.

The AAMC in its response to the Federal Register notice commented on two concerns with the proposed model policy. The first was the deletion of the current 60-day grace period between the time an institution with an approved assurance submits a grant application to an agency and the institutional review board (IRB) certifies approval of the project. The loss of this grace period would impose unnecessary burdens on the IRB review and might delay submission of promising research projects. Secondly, the proposed policy would allow the FDA to continue to use an inspection system to monitor IRB and investigator compliance, rather than the highly successful NIH assurance system. This is not in keeping with the spirit of uniformity across government agencies and it creates an unnecessary burden for institutions.

Comments were sent to Dr. Joan Porter at NIH, who serves as staff director for the Interagency Committee for the Protection of Human Subjects. More than 24 commentators generally endorsed the government-wide policy, but many protested the loss of the 60-day grace period. The Interagency Committee will now draft a final model policy subject to OSTP approval. Publication of the final policy in the Federal Register is expected in 1987; hopefully, implementing regulations for each agency will be published simultaneously.

## AAMC PROJECTS ON TEACHING IN THE AMBULATORY SETTING

The AAMC is planning two projects designed to assist its members in adapting clinical education to the revolutionary changes taking place in the health care delivery system. The first is a small group invitational symposium on "Adapting Clinical Education to New Forms and Sites of Health Care Delivery," to be held in Annapolis, Maryland, December 8-9, 1986. Approximately 25-30 participants will meet and discuss prepared papers on the topic from the perspectives of medicine, surgery, neurology, and ophthalmology. Separate papers will focus on the health care team approach to ambulatory care and its implications for clinical education and the cost and financing of ambulatory care education. A symposium proceedings is planned for the late spring of 1987.

The AAMC has also been awarded a contract from the Health Resources Services Administration to conduct a study and comparison of transitions of medical education programs from hospital inpatient to ambulatory training programs. The study will examine four issues related to these transitions: organization of the educational system, curriculum and educational methodology, faculty interest and participation in the ambulatory setting, and cost and funding sources. It will first identify the perceived and anticipated problems of shifting education into ambulatory clinics, and then explain how those problems have manifested themselves and what solutions have been devised for five selected specialties in nine academic health centers. The project is expected to be completed by the end of 1987.

The symposium is being staffed by the AAMC's Department of Institutional Development, Joseph A. Keyes, Jr., director, while the study will be conducted by the AAMC's Department of Teaching Hospitals, Richard M. Knapp, Ph.D., director.

## BIOMEDICAL ETHICS BOARD

Last year's NIH reauthorization act created a congressional Biomedical Ethics Board to "study and report to the Congress on a continuing basis on the ethical issues arising from the delivery of health care and biomedical and behavioral research...." The Board consists of 12 members, six from the Senate and six from the House of Representatives, equally divided between Democrats and Republicans. Members of the Board are:

### Senate

Lowell Weicker (R-CT)  
Chairman  
David Durenberger (R-MN)  
Gordon Humphrey (R-NH)  
Dale Bumpers (D-AR)  
Albert Gore (D-TN)  
Edward Kennedy (D-MA)

### House

Willis Gradison (R-OH)  
Vice Chairman  
Thomas Bliley (R-VA)  
Thomas Tauke (R-IA)  
Thomas Luken (D-OH)  
J. Roy Rowland (D-GA)  
Henry Waxman (D-CA)

The Board will appoint a 14-member Biomedical Ethics Advisory Committee to conduct the studies and prepare the actual reports. The membership of the Advisory Committee will be as follows:

- o four individuals "distinguished in biomedical or behavioral research";
- o three individuals "distinguished in the practice of medicine or otherwise distinguished in the provision of health care";
- o five individuals "distinguished in one or more of the fields of ethics, theology, law, the natural sciences (other than the biomedical or behavioral sciences), the social sciences, the humanities, health administration, government, and public affairs"; and
- o two individuals "who are representatives of citizens with an interest in biomedical ethics but who possess no specific expertise."

The Board and Advisory Committee will concentrate initially on two specific issues: (1) an examination of the "nature, advisability, and biomedical and ethical implications of exercising any waiver of existing federal protections of human fetuses in research" and (2) a study of the ethical implications of human genetic engineering.

## COUNCIL ON HEALTH CARE TECHNOLOGY

The Health Promotion and Disease Prevention Amendments of 1984 (Public Law 98-551) mandated the formation of a Council on Health Care Technology. The purposes of this Council are to promote the development and application of appropriate health care technology assessments and to review existing health care technologies to identify obsolete or inappropriately used technologies. The establishment of this Council is consistent with recommendations made by a 1983 Institute of Medicine (IOM) report entitled "A Consortium for Assessing Medical Technology." This report cited the lack of a suitable entity to coordinate existing efforts in medical technology assessment.

One of the primary functions of the Council is to serve as a clearinghouse on health care technologies and assessment. Other mandated responsibilities are to:

- o collect and analyze data concerning specific health care technologies;
- o identify needs in assessment and research on methods;
- o develop and evaluate assessment criteria and methods;
- o promote education, training, and technical assistance in the use of assessment methods and results; and
- o stimulate, coordinate, and commission assessments.

One of the early activities of the Council will be to identify and track technologies in transition. This information will be used to monitor the development, diffusion, and acceptability of technologies.

The Council is seeking financial self-sufficiency through support from both the public and private sectors, and will study the feasibility of providing various revenue-generating services. Initial federal funding for the Council through the National Center for Health Services Research and Health Care Technology Assessment was approved in December 1985. Federal funding for the Council must be matched 2:1 by funds from private sources. The Council is seeking funds from health insurers, medical professional organizations, health product makers, hospitals, health maintenance organizations, and business and labor groups.

The IOM appointed the initial members to the Council in the spring of 1986. These members are:

William N. Hubbard, Jr., M.D., former president of The Upjohn Company, chairman

Jeremiah A. Barondess, M.D., professor of clinical medicine, Cornell University Medical College, co-chairman

Herbert L. Abrams, M.D., professor of radiology, Stanford University School of Medicine

Richard E. Behrman, M.D., J.D., dean, Case Western Reserve University School of Medicine

Paul A. Ebert, M.D., chairman of surgery, University of California-San Francisco

Paul S. Entmacher, M.D., vice president and chief medical director, Metropolitan Life Insurance Company

Melvin A. Glasser, director, Health Security Action Council

Gerald D. Laubach, Ph.D., president, Pfizer, Inc.

Walter B. Maher, director, employee benefits and health services, Chrysler Corporation

Lawrence C. Morris, Jr., senior vice president, health benefits management, Blue Cross and Blue Shield Association

C. Frederick Mostetter, Ph.D., chairman of health policy and management, Harvard School of Public Health

Mary O. Munding, D.P.H., dean, School of Nursing, Columbia University

Anne A. Scitovsky, chief, health economics department, Research Institute, Palo Alto Medical Foundation

C. Thomas Smith, president, Yale-New Haven Hospital

Gail L. Warden, chief executive officer, Group Health Cooperative of Puget Sound