AGENDA

COUNCIL OF ACADEMIC SOCIETIES

ANNUAL MEETING

100th

ANNUAL MEETING

October 29-31, 1989
Washington Hilton Hotel
Washington, D. C.

FUTURE MEETING DATES

CAS Spring Meeting San Antonio, Texas	March 14-16, 1990
CAS/AAMC Annual Meeting San Francisco	October 20-25, 1990
CAS Spring Meeting Savannah, Georgia	March 21-23, 1991
CAS/AAMC Annual Meeting Washington, D. C.	November 9-14, 1991

SCHEDULE

Council of Academic Societies Annual Meeting
Washington Hilton Hotel
October 29-31, 1989

Sunday, October 29, 1989

2:00 - 4:00 p.m.	Council of Academic Societies Plenary Session "In Defense of Animal Research: Models for Effective Action"	Ballroom West
4:00 - 6:00 p.m.	AAMC Plenary Session Presentation of Research, Flexner, and AOA Awards AAMC Chairman's and President's Addresses Alan Gregg Lecture The Honorable Louis W. Sullivan, M.D. Secretary of Health and Human Services	
6:00 - 7:30 p.m.	AAMC General Reception	

Monday, October 30, 1989

9:00 - 11:30 a.m.	AAMC Plenary Session John A. D. Cooper Lecture The Honorable Lauro F. Cavazos, Ph.D. Secretary of Education "Medical Student Education: Sounds, Alarums, and Excursions" Daniel D. Federman, M.D., Dean for Students and Alumni, Harvard Medical School "Graduate Medical Education: New Initiatives in the Changing Environment" Spencer Foreman, M.D., President, Montefiore Medical Center	
1:00 - 4:00 p.m.	Council of Academic Societies Business Meeting	Georgetown Room
6:00 - 7:00 p.m.	Council of Academic Societies Reception	Georgetown Room East

Tuesday, October 31, 1989

8:00 - 9:00 a.m.	AAMC Assembly
10:30 a.m. - 12:00 noon	AAMC Special General Session: Rural Health

AGENDA

COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

October 30, 1989
Georgetown Room
Washington Hilton Hotel
Washington, D. C.

I. Chairman's Report
Ernst R. Jaffe', M.D.

II. President's Report
Robert G. Petersdorf, M.D.

III. CAS Staff Report
Thomas E. Malone, Ph.D.

IV. Action and Discussion Items

K. Report on the autopsy
Vivian W. Pinn-Wiggins, M.D.

L. Assessing Change in Medical Education
Louis J. Kettel, M.D.

M. Recognition of Retiring CAS Administrative Board Members

V. Information Items

A. 1990 CAS Spring Meeting

B. Issues Update

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
SPRING MEETING

March 15-17, 1989
Sonesta Village Hotel
Orlando, Florida

Orientation Session

A luncheon and orientation session for new CAS Representatives was held Wednesday afternoon, March 15. Presentations on their activities and responsibilities were given by Robert Petersdorf, M.D. and John Sherman, Ph.D. as well as the Vice Presidents or Associate Vice Presidents for all AAMC Operating Divisions. Ernst Jaffe', M.D. addressed the group on the governance, structure and operations of the CAS, and a panel discussion on the role of the CAS Representative was led by Joe Coulter, Ph.D. Other panelists were Drs. William Drucker, Myron Genel, and Gordon Kaye.

Plenary Session -- American Medical Faculty in the 21st Century: Challenges and Responsibilities

The keynote address, "The Demographics of Our Faculties: Who Will They Be and What Will They Do?" was presented by David R. Challoner, M.D., Vice President for Health Affairs at the University of Florida. He presented very striking data to support the thesis that there would be an inadequate number of researchers in the 1990s to produce the current quality of biomedical research, noted the decreasing percentage of MDs and even PhDs with at least six months of postdoctoral research training, and commented on the decreasing percentage of younger faculty at medical schools with an increasing percentage of older faculty. He concluded, therefore, that medical schools would be unable to provide the current and projected needs in terms of research personnel, and might face crises in supplying their own staff needs. He suggested that more faculty with research experience be hired in the face of the decreasing supply and the aging of the faculty. Noting that enlarging faculty was unrealistic, he recommended retrenchment, not growth. Dr. Challoner proposed that graying faculty assume non-research roles, schools reevaluate their tenure policies, and that medical schools develop consortia to conserve research resources. Finally, he urged the medical schools to find and admit the best students and channel them to research-intensive schools. The less research-intensive medical schools should do clinical trials which would be less expensive in terms of equipment and would train better clinicians.

Dr. Jaffe's CAS Chairman's address, "Modern American Medicine: A Plea for Positive Thinking," reviewed the positive aspects of careers in medicine and in particular, in academic medicine. He expressed great concern about increasing incidents of misconduct in science and the high priority given in recent years to the financial rewards of medicine, rather than the altruistic rewards. Dr. Jaffe' urged the group to stop denigrating the profession and instead to concentrate on inculcating moral values into medical students. He presented a model of medical education in which a broad liberal education would be required for medical students, and science training as a real introduction to clinical medicine would occur in the first two years of medical school. The ideal educational track would be a 4 year liberal arts program, 4 years of biomedical education and one year of rotating internship for the M.D. degree, then further specialty or subspecialty training. He also expressed support for the revitalization of "pay back" schemes, in which financial aid for senior medical students and early graduate training is repaid by practice in an underserved area. A similar program for Ph.D. researchers to teach or work in industry should also be available.

Itzhak Jacoby, Ph.D. reported to the CAS on the Institute of Medicine Study of Physician Manpower Requirements of the Veterans Administration, which he directs. The very pervasive impact of the Veterans Administration on American medicine has been an important finding of the Study Committee to date. The findings and conclusions of the Committee are expected to be available in about one year, and Dr. Jacoby

strongly encouraged the CAS to provide input and suggestions to the Committee. VA hospitals are often an important resource in individual communities. In 1984, the Veterans Administration set standards for all professions other than physicians in their facilities, but did not have the information necessary to set physician standards. Coupled with questions being raised by the Office of Management and Budget about physician manpower at the VA, internal VA concerns led to the development of the IOM study. The IOM Committee is chaired by Dr. Challoner, and its members include both VA and non-VA clinicians as well as economists. Panels have been set up to address Methodology, Affiliations, Physician Extenders (e.g., nurse practitioners), and Specialties. Louis Kettel, M.D., Associate Vice President for Academic Affairs at the AAMC, serves on the Affiliations Panel. Dr. Jacoby discussed the methodology that the study hopes to use, and stressed the pivotal principles that Veterans Administration facilities provide care and must be properly staffed to render such care; and that where teaching and research are occurring, these activities are interwoven and inseparable, and often are specific to the medical school/VA medical center. He will report back to the CAS at its Annual Meeting in October.

"Closing the Gap Between Medical Education and Medical Practice," was the title of the thought-provoking address given by Donald W. Light, Ph.D., Professor of Social Psychiatry and Sociology at the University of Medicine and Dentistry of New Jersey and Rutgers University. Dr. Light called the 1970s the "golden era of medical education," and cautioned that what is being perceived as drops in applicant pools and NIH funding are actually returns to historically normative levels. Dr. Light questioned the group about what medical schools actually do. Society believes that medical schools train doctors, but in fact, they are becoming health service conglomerates and biotechnology research centers. They serve society's greater interests, but have a poor reputation for serving the needs of public health. Dr. Light, in informally surveying the CAS membership, received widely varying answers to his questioning whether medical schools need to do research to educate practicing physicians. He expressed a concern that undergraduate and graduate medical education have been separated in ways that have more to do with turf than need, and wondered whether anyone at a specific medical school was actually hired to teach medical students instead of doing research or providing practice income.

Dr. Light cited the "buyers' revolt" which has occurred in all segments of the American economy in recent years. Those who are paying for medical education and medical care want to know how their money is spent and see a value for it. He presented the thesis that medical schools and academic medical centers have changed less than any other sector of the health care industry in response to the buyers' revolt. Since Medicare and state governments have begun cutting their financial support for medical education, medical schools depend increasingly on practice and research income, thus giving education a lower priority. He also stated that researchers are under such pressure to bring in research dollars that they no longer have time to perform the job (education) for which they are paid their base salaries. The changes in housestaff hours wrought by New York State have created incentives to train more primary care physicians and fewer specialists. Currently, 30% of all physicians are primary care physicians, but 70% of the population has primary care needs. To meet this need, primary care and clinical time must be appropriately rewarded and compensated. The reduction of Medicare rates invites exploitation and neglect of the poor. The expectations placed on physicians are to meet the needs of society, but when physicians treat the indigent, they do not bring in enough income to cover their overhead costs. The balance intended by Flexner has gotten out of equilibrium due to financial pressures. Fiscal cuts have left the old system of medical education intact but starving.

Dr. Light addressed other financial pressures on the medical profession, most notably the high debt rates of beginning physicians. He believes that such debts affect career choices and are creating social class discrimination for the medical school applicant pool. He suggested a voucher system for free medical education for all students in primary care. He also proposed comparative institutional studies of how students learn in research-intensive and non-research-intensive schools, with follow-up 10 to 15 years after their medical education is completed to see how both groups cope with the growing obsolescence of their education.

The CAS then broke into three discussion groups, fueled by the plenary speakers. "Is the triple threat academician obsolete?" was led by Dr. Jaffe' and Thomas C. King, M.D. "How do we recruit future faculty?" was led by Drs. Coulter and Genel, and "How should academic units in medical schools be organized?" was led by Douglas E. Kelly, Ph.D., Wilton Bunch, M.D., Ph.D., and Lewis Siegel, Ph.D.

The discussion group considering whether the triple threat academician is obsolete reached the consensus that at least a "double threat" is necessary to function in academic medicine. Whatever else one does, one must also teach. The concept of a three-cornered stool was long ago replaced by a four-cornered one, with the administrative/management role appearing early in the academic medical career, and remaining at least constant and perhaps increasing throughout the career. The sharing of information is an obligation of academic medicine, whether it be through publishing or presentations as well as in the classroom. Concern was expressed by the discussion group that the concept of peer review is lost in clinical research, and that clinical researchers are being judged by inappropriate standards in promotion and tenure decisions, as well as in research. Little or no preparation for the administrative, research and teaching roles is provided in medical school; MDs are trained for clinical practice only. There is a need to spend some effort on training future academicians for these other roles and to foster role models. A great irony of academic medicine is that those who are good at one of these roles "get punished" for being good, i.e. the faculty member who is perceived as a good teacher gets more teaching assignments, and thus less opportunity and time for research. This is especially hard on good clinicians due to the pressure to produce income from practice. The group noted that the only way to reward teaching roles is through redistribution of current income, as new income sources are not likely to become available. A need was expressed to develop new academic tracks and get clear definitions of what the labels on such tracks mean. The group recommended that the CAS develop standard job titles for all disciplines. A second consensus reached was that if an individual cannot be a triple-threat, then it is incumbent upon the department chair to make certain the department covers all other functions. A way to effect measurable evaluation of teaching ability should be built into the system, so that good teachers, especially younger faculty members, may be rewarded, and assisted with their appointments and promotions. Great concern was expressed that young faculty are sometimes unfairly brought into a medical school to do work that will protect older faculty so they can participate in outside activities (such as CAS meetings). Medical schools need to be more forthcoming about assigning responsibilities, and compensating faculty accordingly.

The group considering issues of recruitment of future faculty raised the question of how you train and recruit people without knowledge of what role they are being trained to perform. This group acknowledged that individual faculty members may serve with various amounts of responsibility in the areas of teaching, service, research, and administration, but stated that no faculty member should be doing any of the other roles without teaching. Goals were set by this group with strategies for reaching them, as follows:

Goal 1. Make academic medical careers more attractive.

Strategies:

1. Evolve more control over lifestyles.
2. Aim recruitment at increasingly younger groups, especially high school students.
3. Deliver the message ourselves.
4. Encourage the AAMC and other medical groups to do better public relations.
5. Develop summer programs for high school students.
6. Close the gap in salaries between the private sector and academe.
7. Improve community affairs.
8. Develop special programs for women and minorities.
9. Increase NIH funding.

Goal 2. Prepare future faculty appropriately, especially for their role as educators.
Strategies:

1. Develop better role models.
2. Develop "how to teach" courses or programs. It is probably necessary to develop separate ones for specific disciplines, rather than relying on a generic program for all specialties.
3. Ask the LCME to consider the education of teachers in the accreditation process.
4. Improve communication with professional educators.
5. Evaluate teaching in promotion and tenure decisions, considering the outcomes of teaching.

The group which considered the organization of academic units in medical schools first raised several questions: What patterns of reorganizations are emerging? Does reorganization favor research at the expense of teaching? Is reorganization driven by money and is that acceptable? Can faculty serve both traditional structure and interdepartmental programs? and To what extent does technology transfer drive reorganization? Dr. Siegel presented the reorganization plan followed by Duke University, which was driven by faculty concerns. He feels that it has been sensitive to both teaching and research, but acknowledged that Duke had enough financial security to institute changes which resulted in the hiring of additional basic science faculty. Dr. Bunch presented a rationale for retaining the traditional structure at the University of South Florida. The USF decision in response to the proposed development of a cancer center and the formation of an oncology department. Reasons for the decision not to reorganize included financial considerations and continuity of interest. The University of Alabama-Birmingham model was also discussed, as it has maintained traditional departments while also fostering supradepartmental centers, with administrative chores shared by the traditional departments. This plan provides much flexibility. This group reached ten points of consensus:

1. Any reorganization must serve both education and research.
2. Any reorganization must retain or promote the integrity of interaction between basic and clinical sciences.
3. Reorganization should not be driven by a quest for money or new technology.
4. Reorganization can be used to respond to national research needs, but can also be done by forming clusters (e.g., UAB).
5. Reorganization can extend beyond the bounds of the medical school, but is apt to get out of control if it extends too far beyond those bounds.
6. There is danger in increasing the number of departments in a medical school, as it strains administration and accountability.
7. Technology transfer has the potential to drive reorganization, but it has not yet done so.
8. Efforts to reorganize may add to the overload of pressures already felt by academicians.
9. The uniqueness of the institution must be considered in reorganization, especially with regard to faculty morale.
10. The AAMC should assess current reorganization activities.

Business Meeting

I. Chairman's Report - Ernst R. Jaffe', M.D.

Due to the wealth of riches on the agenda, no report was given.

II. President's Report - Robert G. Petersdorf, M.D.

Dr. Petersdorf stated that executive staff recruitment is now complete with the appointment of Douglas E. Kelly, Ph.D. as AAMC's new Associate Vice President for Biomedical Research. He announced that the AAMC has been through a strategic planning process, highlighted initiatives in each operational division, and outlined the plans for the new AAMC headquarters building.

III. Action and Discussion Items

A. Minutes -- The minutes of the 1988 Annual Meeting were approved as submitted.

B. Membership Applications

Lewis Aronow, Ph.D. led the discussion of the membership application of the American College of Clinical Pharmacology. The CAS Administrative Board and Executive Council had previously approved this application.

ACTION: The CAS unanimously voted to approve the American College of Clinical Pharmacology for membership.

Joel Sacks, M.D. presented the application of the Association of Academic Health Science Library Directors, which had also been previously approved by the CAS Administrative Board and Executive Council.

ACTION: The CAS unanimously approved the membership application of the AAHSLD.

Final action on both membership applications will be taken by the AAMC Assembly at the Annual Meeting in October.

M. Declining Autopsy Rates -- Vivian W. Pinn-Wiggins, M.D.

Dr. Pinn-Wiggins advised the CAS that she, on behalf of the Association of Pathology Chairmen, met with senior staff members of the AAMC to discuss and clarify possible roles for the AAMC in addressing the problem of declining autopsy rates. The pathologists are considering various strategies, and she will bring progress reports back to the CAS as they develop.

L. AAMC Ad Hoc Committee on Misconduct and Conflict of Interest -- David H. Cohen, Ph.D., Chair

This committee was formed to review and adapt the Framework Document for Institutional Policies and Procedures to Deal with Misconduct in Science for the academic medicine community. The document on misconduct recently produced by the Institute of Medicine has not yet been reviewed by the Committee, but it plans to do so since it has recommendations for professional societies. As Congressional interest in issues of misconduct increased, so did the responsibilities of the Ad Hoc Committee. At an early Committee meeting, Dr. Diana Zuckerman, on the staff of Rep. Ted Weiss (D-NY) brought up the topic

of conflict of interest, an area where the academic medical community has even greater exposure. The Ad Hoc Committee is beginning an effort to develop conflict of interest guidelines. Dr. Cohen reminded the CAS that perception is as important as reality on this issue.

G. Report from the CAS Working Group on an Educator/Scholar Award -- Douglas E. Kelly, Ph.D., Chair

This project developed from the need to provide recognition and research support for successful teachers. Various foundations will be approached for financial support.

C. AMA-FREIDA -- Beverley D. Rowley, Ph.D.

The FREIDA (Fellowship and Residency Electronic Interactive Database Access) system is essentially an electronic version of the Directory of Graduate Medical Education. The AMA is also working on developing an electronic vacancy bulletin board. Dr. Rowley gave a demonstration, using slides, of how the program will work.

D. Clinical Pharmacology Education: A Paradigm for Basic Sciences-based Education in the Clinical Years of Medical School -- Richard Weinshilboum, M.D.

This presentation was a follow-up to Dr. Weinshilboum's program at the 1987 CAS Annual Meeting. Sponsored by the Council on Medical Student Education in Clinical Pharmacology and Therapeutics, which consists of the American College of Clinical Pharmacology, the American Society for Pharmacology and Experimental Therapeutics, the American Society for Clinical Pharmacology and Therapeutics, and the Association for Medical School Pharmacology, this project is working to enhance medical student education in pharmacology. Dr. Weinshilboum raised the question of how medical education includes disciplines that do not fit into the traditional curriculum, and how the AAMC can define operational techniques to deal with bridge disciplines. The pharmacology societies formally requested that the AAMC appoint a Council of Academic Societies-Group on Medical Education task force to deal with this issue. Dr. Weinshilboum elaborated on the need to prepare young physicians to handle new drugs and changing information on drugs, and encouraged that medical school curricula change to accommodate emerging disciplines.

E. AAMC Committee on Governance and Structure -- D. Kay Clawson, M.D.

In the 25 years since the Coggeshall Report was implemented, no basic change has occurred in the AAMC's governance and structure. Important players in medical education have no voice in the AAMC, and a committee consisting of the 5 immediate past Chairs, and the present Chair and Chair-Elect was formed to evaluate the current structure. John Colloton chairs this Committee, and Dr. Sherman staffs it. The Committee expects to produce a report which will be acted upon at the Annual Meeting in October. Among the questions it will consider are whether the name of the AAMC is still appropriate and reflective of the constituency, and if other groups such as residents, health science vice presidents, graduate and continuing medical educators, postdoctoral research trainees, and research administrators should have AAMC representation. Concern was expressed by various CAS Representatives that creating new Councils for Vice Presidents and Residents would diminish the role of faculty, and give high impact to administrators, and it was suggested that the Vice Presidents join with the Deans to form a Council of Institutions to replace the Council of Deans. Dr. Clawson stated that residents would probably join the Council of Teaching Hospitals just as the Organization of Student Representatives relates to the Council of Deans. Input from CAS Representatives and societies was solicited.

F. CAS Nominating Committee -- Joe Coulter, Ph.D., Chair

Dr. Coulter reminded the CAS that the Nominating Committee will be meeting via conference call in May and encouraged anyone who would like to submit a nomination to do so by April 25. Members of the Nominating Committee are:

Joe Coulter, Ph.D., Chair, Society for Neuroscience and University of Iowa
Ernst R. Jaffe', M.D., American Society of Hematology and Albert Einstein College of Medicine
Gordon Kaye, Ph.D., American Association of Anatomists, and Albany Medical College
Jack L. Kostyo, Ph.D., American Physiological Society and University of Michigan
Barbara McLaughlin, Ph.D., American Society for Cell Biology and University of Louisville
Norman Snow, M.D., Association for Surgical Education and Cleveland Metropolitan General Hospital
Paul Van Arsdel, M.D., American Academy of Allergy and Immunology and University of Washington

G. Report from the CAS Working Group on Faculty Development and Evaluation -- Joe Coulter, Ph.D., Chair

Dr. Coulter has met with senior AAMC staff to discuss the possibility of undertaking a project to address faculty development and evaluation. Writing of a document with guidelines for faculty development and evaluation is under consideration. Dr. Coulter solicited input from CAS Representatives on this project.

Report from the CAS Working Group on Discontinuities in Medical Education -- Frank G. Moody, M.D., Chair

This group recommends that there be a central coordinating body with authority over the entire process of medical education to include graduate medical education; that the AAMC assist a few selected medical schools in setting up and testing the advantages of the Ebert-Ginzberg sic year curriculum; and that the AAMC encourage the medical schools, and the accrediting and certifying bodies for graduate medical education, to transform the fourth year of medical school into a rotating internship.

H. AAMC Strategic Plan -- John F. Sherman, Ph.D.

The AAMC has developed a strategic plan over the last several months, with new initiatives for each operational division. The format of the document was explained and the input of CAS Representatives requested.

I. Legislative Update -- Richard Knapp, Ph.D.

Dr. Knapp reviewed the ways the AAMC Office of Government Relations approaches its assignment, and discussed the value of its becoming an important source and resource for Congressional and Executive Branch staff. The fetal tissue and fetal research document produced by the AAMC last year has been very important in government relations work. Documents will be produced in the near future on research training and the indirect medical education subsidy. A public policy column is appearing in Academic Medicine, and authors for the first few months include Reps. Waxman, Stark, Dingell, and Sens. Burdick and Cranston.

Dr. Knapp explained the interaction between the Office of Government Relations and the various AAMC program staff. Major issues facing this community in the coming months include Veterans Administration appropriations, indirect medical education payments from Medicare, and NIH/ADAMHA appropriations. On VA appropriations, a group called Friends of the VA has been formed. Fifty-five organizations have endorsed its funding recommendations to date, and letters from Deans whose schools have VA affiliations have been generated. Members of the Council of Deans have testified before Congress on VA appropriations in recent months. Rep. Traxler met with the COD Administrative Board in February, about this important issue. Data produced by AAMC's Division of Clinical Services helped raise the ProPAC recommendation on indirect medical education payments from Medicare from 4.4% to 6.6%. A pink (action) memorandum was recently mailed to CAS, COD and COTH members on this subject, and Dr. Knapp's office will be following up with telephone calls next week to insure that letters are going out to Congress on this issue.

The APHIS regulations on animal welfare appeared in the Federal Register March 15. Academic medicine can anticipate major problems with these. CAS members will be asked to be active as this issue develops.

David Moore described the Ad Hoc Group on Medical Research Funding, noting that it is the AAMC's and the research community's major effort on the annual issue of funding for the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. Two separate issues in which the CAS should be involved are the budget resolution and appropriations. Hearings on the budget resolution are underway. The AAMC is working with the Coalition for Health Funding and the National Health Council to develop appropriate budget levels. A draft letter with lists of House and Senate Budget Committee members was distributed, and CAS Representatives were urged to write both the Budget Committee members and their own Congressman and Senators as soon as possible. On appropriations, the Ad Hoc Group brochure will be published in the very near future. It is directed at Congress, and Mr. Moore encouraged all CAS societies to endorse the Ad Hoc Group recommendations. An organization called Research! America has been formed, with former Senator Lowell Weicker as its director. Its purpose is a public education campaign to raise the level of awareness and interest in medical research, but it is currently in a formative stage.

J. AAMC Task Force on Physician Supply -- Joseph Keyes, J.D.

The Physician Supply Task Force was appointed in January 1987 with Daniel Tosteson, M.D. as its Chair. Chairs of the four committees are Drs. Farber, Rabkin, Moy, and Corn, and the subjects of those groups are medical student education, specialty distribution, foreign medical graduates and quality control, and training of biomedical scientists, respectively. The recommendations of the task force are complete and the final report will be forthcoming. No targets for numbers of physicians were recommended, as there is no reliable way to predict demand. It is expected that there will be an abundance of physicians, and the physician/population ratio will likely be double that of the 1960s. The recommendations are:

1. Quality, not quantity, should be top priority for entering medical school classes. Schools are encouraged to limit the number of acceptances rather than reduce standards.
2. A recruitment campaign should be begun.
3. Efforts should be undertaken to increase underrepresented minorities, preserve the gains made in recent years, and expand the pool of minority applicants. The Task Force recommended that the medical education community work with schools, back to the primary school level, in accomplishing this goal.
4. Requirements for national service should be investigated.
5. Health services research was recommended, particularly in developing indices of overdoctoring, and whether seeing fewer

patients will harm a physician's ability to maintain his or her skills.

6. No recommendations were made on the number of physicians per specialty.
7. Program size determinations should be made in consideration of national needs.
8. U.S. licensure should be limited to those who complete accredited residency programs.
9. Foreign medical graduates' acceptance into accredited residency programs should be conditional on passage of the ECFMG. Spoken English and clinical skills are essential for acceptance.
10. The International Medical Scholars Program should be developed.
11. The training of biomedical scientists was endorsed as equal in importance to the training of physicians and provision of patient care.

K. AAMC Framework Document for Institutional Policies and Procedures to Deal with Misconduct in Science -- Allan Shipp

This document was developed by an interassociation working group of higher education associations, FASEB, the American Society of Microbiology and AAMC. It provides guidance for institutions on how to handle allegations of misconduct, meets current regulatory requirements, and anticipates future regulation. The AAMC version of the Framework document includes a section on preventing misconduct. The final document will be mailed out to the AAMC constituency in the next two weeks.

N. Medicare Proposed Regulations on Payment for Physician Services Furnished in Teaching Settings -- Joyce V. Kelly, Ph.D.

A memorandum requesting action on the draft regulations was mailed to the AAMC constituency in late February. It appears that HCFA has relaxed attending physician criteria for billing fees for all outpatient services, including family practice and emergency medicine. Concern was expressed about the proposed offset of practice plan income returned to the provider, against allowable Part A costs. The offset is conditional depending upon the relationship between the hospital, medical school, and practice plan. Detailed technical questions on these regulations should be addressed to Robert D'Antuono of the AAMC staff, who is working closely with HCFA to elicit the intent of the regulations. These regulations are expected to be implemented within the next six months. There was a meeting March 6 with Washington-based physician organizations, including the American Society of Internal Medicine and the American Medical Association, to coordinate community response and understanding. Comment letters are due at HCFA on April 10, and a group chaired by Hiram Polk, M.D., will meet on March 23 to help develop the AAMC comment letter.

O. Proposed Regulations on Medicare's Payment for Direct Graduate Medical Education (GME) Costs -- Joyce V. Kelly, Ph.D.

These proposed regulations affect Medicare Part A payments for direct GME costs, including stipends and fringe benefits for house officers, salaries of supervising physicians, and educational overhead. Essentially, the regulations provide for HCFA reimbursement of each provider's own 1984 historical costs per resident, adjusted for inflation. Dr. Petersdorf issued blue and pink memoranda on October 13 and November 9, 1988, respectively, calling members' attention to a number of technical issues in calculating costs (the numerator of the ratio) and counting residents (the denominator of the ratio). Final regulations are expected shortly. HCFA has also expressed interest in the wide variation among hospitals in their reported direct costs per resident. The AAMC recommends that providers examine their own reported costs

compared to the 1984 mean value of $53,500. Hospitals with 1984 costs considerably above this amount may be at risk. In all activities, AAMC staff are guided by the principle that third party payers continue to support medical education as an investment in the future of health care practitioners.

P. Uniform Pathway to Licensure -- Robert Volle, Ph.D.

The Task Force on Uniform Examination for Licensure includes the Federation of State Medical Boards, Education Commission for Foreign Medical Graduates, National Board of Medical Examiners, American Medical Association, AAMC, Accreditation Council for Graduate Medical Education, National Board of Osteopathic Medical Examiners, and U.S. Department of Health and Human Services. The current dual pathway system is:

For graduates of LCME-accredited schools of medicine:

NBME Part I
NBME Part II
MD degree plus one year of graduate medical education
NBME Part III

Or, MD degree
FLEX I
FLEX II

The National Board certificate is not recognized in Texas, Louisiana, Puerto Rico and the Virgin Islands, where the FLEX examination is used instead. Twenty percent of all medical students take the FLEX examination and 80% take NBME.

For graduates of non-LCME-accredited schools:

FMGEMS I	or	NBME Part I
FMGEMS II	or	NBME Part II

MD degree
other ECFMG requirements
ECFMG certificate
graduate medical education
FLEX I
FLEX II

The proposed single pathway for LCME or non-LCME graduates would be:

Step I (NBME Part I)
Step II (NBME Part II)
MD or ECFMG certificate
graduate medical education, minimum one year
Step III

Over the next six to seven months, this plan will be announced around the country, and input solicited. The NBME Board will review the proposal at its annual meeting later this month, and if approved, will become official policy in March of 1990. A preliminary review indicates no impairment of LCME and ACGME work with this plan.

Dr. Jaffe' thanked the presenters, announced attendance, and concluded the meeting with a traditional Irish benediction for St. Patrick's Day.

COUNCIL OF ACADEMIC SOCIETIES
SPRING MEETING

Sonesta Village Hotel
Orlando, Florida
March 15-17, 1989

Registration

Representative	Society
Warren Y. Adkins	Association of Academic Departments of Otolaryngology
S. Craighead Alexander	Society of Academic Anesthesia Chairmen
Milton H. Alper	Association of University Anesthetists
Lewis Aronow	American Society for Pharmacology and Experimental Therapeutics
DeWitt Baldwin	Association for the Behavioral Sciences and Medical Education
J. Bronwyn Bateman	American Academy of Ophthalmology
A. O. Berg	Society of Teachers of Family Medicine
Kenneth I. Berns	Association of Medical School Microbiology Chairman
Hal G. Bingham	American Association of Plastic Surgeons
Mordecai Blaustein	Association of Chairmen of Departments of Physiology
Thornton Bryan	Association of Departments of Family Medicine
Wilton Bunch	American Academy of Orthopaedic Surgeons
Rosalie A. Burns	American Academy of Neurology
Rita Charon	Society for Health and Human Values
Lanny Garth Close	Society of University Otolaryngologists
David H. Cohen	Society for Neuroscience, AAMC Chair-Elect
Joe Coulter	Society for Neuroscience
Frank Davidoff	American College of Physicians
William R. Drucker	American Association for the Surgery of Trauma
William Easterling	American College of Obstetricians and Gynecologists
K. E. Ebner	American Society for Biochemistry and Molecular Biology
Burton S. Epstein	Society of Academic Anesthesia Chairmen
Robert M. Epstein	Association of Anesthesia Program Directors
Harold J. Fallon	Association of Professors of Medicine
John Farrar	American Gastroenterological Association
Paul J. Friedman	Association of University Radiologists
Myron Genel	American Pediatric Society
George L. Ginsberg	American Association of Directors of Psychiatric Residency Training
Dorothea D. Glass	Association of Academic Psychiatrics

Arthur E. Grant	American Academy of Physical Medicine and Rehabilitation
Glenn C. Hamilton	Society of Teachers of Emergency Medicine
John B. Hanks	Association for Academic Surgery
Douglas W. Hanto	Society of University Surgeons
Lee Harker	Society of University Otolaryngologists
Irwin N. Hassenfeld	Association of Directors of Medical Student Education in Psychiatry
George A. Hedge	American Physiological Society
David Herndon	Surgical Infection Society
Solomon G. Hershey	Society of Critical Care Medicine
Gwendolyn R. Hogan	Child Neurology Society
Aubrey Hough, Jr.	Association of Pathology Chairmen
Harry S. Jacob	American Society of Hematology
Ernst R. Jaffe'	American Society of Hematology
Everette James, Jr.	Association of University Radiologists
Gordon I. Kaye	American Association of Anatomists
Douglas E. Kelly	American Association of Anatomists
Thomas C. King	American Association for Thoracic Surgery
Douglas R. Knab	Association of Professors of Gynecology and Obstetrics
Robert Kohut	Association of Academic Departments of Otolaryngology
C. Philip Larson	Association of University Anesthetists
Richard Carl Levy	University Association for Emergency Medicine
Roger R. Markwald	American Association of Anatomists
Harry Mayhew	Association of Departments of Family Medicine
Barbara McLaughlin	American Society for Cell Biology
David G. McLeod	Society of University Urologists
Frank G. Moody	Society of Surgical Chairmen
Alan Niemes	Association for Medical School Pharmacology
Richard M. Nowak	Society of Teachers of Emergency Medicine
George Pappas	American Society for Cell Biology
Herbert Pardes	American Psychiatric Association
Vivian Pinn-Wiggins	Association of Pathology Chairmen
Henry Pitt	Society for Surgery of the Alimentary Tract
Arthur Prange, Jr.	American College of Neuropsychopharmacology
Judson Randolph	American Surgical Association
H. David Reines	Society for Critical Care Medicine
Louis F. Rittelmeyer	Association for Academic Psychiatry

Carolyn B. Robinowitz	Association for Academic Psychiatry
Beverley D. Rowley	Association for the Behavioral Sciences and Medical Education
Joel G. Sacks	American Academy of Ophthalmology
Sanford Schwartz	American Federation of Ophthalmology
Steven P. Shelov	Ambulatory Pediatric Association
Eizabeth M. Short	American Society of Human Genetics
Norman Snow	Association for Surgical Education
Larry P. Solomonson	Association of Medical School Departments of Biochemistry
Stefan Stein	American Association of Directors of Psychiatric Residency Training
Jerome Sutin	American Association of Anatomists
Richard Weinshilboum	American Society for Clinical Pharmacology and Therapeutics
Roland Weinsier	American Society for Clinical Nutrition
William West	American Society for Pharmacology and Experimental Therapeutics
Jerry Wiener	American Association of Chairmen of Departments of Psychiatry
James Winkelman	Academy of Clinical Laboratory Physicians and Scientist
Robert D. Yates	Association of Anatomy Chairmen

Guests

David R. Challoner	Vice President for Health Affairs, University of Florida
D. Kay Clawson	Executive Vice Chancellor, University of Kansas School of Medicine, AAMC Chair
W. Dale Dauphinee	Society of Medial College Directors of Continuing Medical Education
Itzhak Jacoby	Institute of Medicine
Donald W. Light	Professor of Social Psychiatry and Sociology, UMDNJ and Rutgers University
Lewis Siegel	Professor of Biochemistry, Duke University School of Medicine
Robert Volle	National Board of Medical Examiners
Karin Wetmore	Harvard Medical School

AAMC Staff

Edwin L. Crocker	Vice President for Administrative Services
Jane Donovan	Administrative Assistant, Division of Biomedical Research
Joyce Kelly	Associate Vice President for Clinical Services
Louis J. Kettel	Associate Vice President for Academic Affairs
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Elizabeth Martin	Vice President for Communications
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Robert G. Petersdorf	President and Chief Executive Officer
John F. Sherman	Executive Vice President
Allan C. Shipp	Staff Associate, Division of Biomedical Research
Kathleen Turner	Assistant Vice President

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: Association of American Medical Colleges
One Dupont Circle NW, Suite 200
Washington, D. C. 20036
Attention: Jane Donovan

NAME OF SOCIETY: Council of Emergency Medicine Residency Directors
Attn: Robert C. Jorden, M.D.
MAILING ADDRESS: 2500 North State Street
Jackson, Mississippi 39216-4505

PURPOSE: The purpose of the council is to improve the quality of emergency care by maintaining a high standard of excellence in emergency medicine training programs. Furthermore the council's purpose is to foster communication between faculty of emergency medicine training programs.

MEMBERSHIP CRITERIA: 1. Must be a residency director of an accredited emergency medicine training program.
OR
2. Must be a designated faculty representative of an accredited emergency medicine training program.

NUMBER OF MEMBERS: 78

NUMBER OF FACULTY MEMBERS: 78

DATE ORGANIZED: May 24, 1989

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

Enclosed 1. Constitution and Bylaws

1st meeting September 14th; program to follow 2. Program and Minutes of Annual Meeting

Application in progress 3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code.

August 29, 1989
Date Completed

Robert C. Jorden
Completed by - Signature

Robert C. Jorden, M.D.
Completed by - Please print

Vice President
Title

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: Association of American Medical Colleges
One Dupont Circle NW, Suite 200
Washington, D. C. 20036
Attention: Jane Donovan

NAME OF SOCIETY: Society for Education in Anesthesia (SEA)

MAILING ADDRESS: 11508 Allecingie Parkway, Suite C
Richmond, VA 23235 (804)-379-5513)

PURPOSE: (See attached)

MEMBERSHIP CRITERIA: (See attached)

NUMBER OF MEMBERS: 604

NUMBER OF FACULTY MEMBERS: Approximately 400

DATE ORGANIZED: 1984

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

Revised 3/4/89 1. Constitution and Bylaws

October 7, 1988 2. Program and Minutes of Annual Meeting

_____ 3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code.

3/27/89
Date Completed

Philip L. Liu
Completed by - Signature

Philip L. Liu, M.D.
Completed by - Please print

President
Title

PURPOSES

The purposes of the organization are:

1. To provide a forum for discussion of matters relating to anesthesia education.
2. To stimulate improvements in anesthesia education of anesthesiologists, residents and medical students.
3. To encourage research in anesthesia education.
4. To collect and disseminate information relating to anesthesia education.
5. To cooperate with other organizations relating to a anesthesia education.

MEMBERSHIP CRITERIA

Any person with a doctorate degree may be a member afer approval of the Membership Committee and receipt of annual dues. Any other person with a demonstrated interest in education of anesthesiologists or medical students may apply for membership by special consideration of the Membership Committee.

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: Association of American Medical Colleges
One Dupont Circle NW, Suite 200
Washington, D. C. 20036
Attention: Jane Donovan

NAME OF SOCIETY: SOCIETY OF MEDICAL COLLEGE DIRECTORS OF CONTINUING MEDICAL EDUCATION
MAILING ADDRESS: C/O AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN AVENUE,
CHICAGO, ILLINOIS 60610
PURPOSE: 1) ESTABLISH NATIONAL FORUM (POLICY, KNOWLEDGE AND RESEARCH) FOR DIRECTORS OF CME
2) IMPROVE QUALITY OF PATIENT CARE THROUGH CONTINUING MEDICAL EDUCATION

MEMBERSHIP CRITERIA:
1) DIRECTOR OF CME AT A MEDICAL COLLEGE BRANCH OR CAMPUS ACCREDITED BY LCME
2) WRITTEN ENDORSEMENT BY THE DEAN
NUMBER OF MEMBERS: 106 FULL VOTING MEMBERS

NUMBER OF FACULTY MEMBERS: 106

DATE ORGANIZED: 1976

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

SEPTEMBER 1988 1. Constitution and Bylaws
PROGRAM: SPRING 1988 and 89
MINUTES FALL 1988 2. Program and Minutes of Annual Meeting

14 NOVEMBER 1983 3. Copy of IRS Approval under Sections 501(c)(3) and 509(a) of the Internal Revenue Code.

11 May 1989
Date Completed

W. Dale Dauphinee
Completed by - Signature

W. DALE DAUPHINEE
Completed by - Please print

PAST PRESIDENT
Title

ELECTION OF MEMBERS TO THE 1990 ADMINISTRATIVE BOARD

The 1989 CAS Nominating Committee met by conference call May 5 and October 11, 1989 to develop a slate of nominees for vacant positions on the Administrative Board. The slate of nominees which resulted from those meetings are as follows:

CHAIR-ELECT	Myron Genel, M.D. American Pediatric Society Associate Dean for Government and Community Affairs Yale University School of Medicine
THREE-YEAR TERMS	Harold J. Fallon, M.D. Association of Professors of Medicine Chairman of Medicine Medical College of Virginia
	George A. Hedge, Ph.D. American Physiological Society Chairman of Physiology West Virginia University
	Barbara J. McLaughlin, Ph.D. American Society for Cell Biology Kentucky Lions Eye Institute University of Louisville
ONE-YEAR TERM	Thomas C. King, M.D. American Association for Thoracic Surgery J. M. Ferrer Professor of Surgery Columbia University

Information about the nominees appears on the following pages.

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Myron Genel, M.D.
Present Location (School) Yale University School of Medicine
CAS Society: American Pediatric Society
Undergraduate School: Moravian College
Degree: B.S. Date: 1957
Medical School: University of Pennsylvania Year Graduated: 1961

Location and Nature of Major Graduate Training:

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

Rotating Intern Mt. Sinai Hospital, NY, 1961-62

Resident in Pediatrics, Children's Hospital of Philadelphia, 1962-64

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

Pediatric Endocrinology, Johns Hopkins Hospital, 1966-67

Genetics & Inherited Metabolic Diseases, Children's Hosp. of Philadelphia, 1967-69

Board Certification:

Pediatrics 1967 (Specialty/Date)

Pediatric Endocrinology 1978 (Specialty/Date)

Academic Appointments (With Dates): All Yale Univ. School of Medicine

1971-76 Assistant Professor of Pediatrics

1971-86 Program Director, Children's Clinical Research Center

1976-81 Associate Professor of Pediatrics

1981-present-Professor of Pediatrics

1985-present-Associate Dean, Government and Community Affairs

Societies/Affiliations:

American Academy of Pediatrics, American Pediatric Society

American Diabetes Assoc., American Public Health Assoc., American Federation for Clinical Research, American Society for Bone & Mineral Research, Endocrine Society, Lawson Wilkins Pediatric Endocrine Society, Society for Pediatric Research

Honors/Awards:

1) Annual Award, CT Campaign Against Cooley's Anemia, 1979

2) Robert Wood Johnson Health Policy Fellowship, Institute of Medicine, National Academy of Sciences, 1982-83

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Harold J. Fallon, M.D.
Present Location (School) Medical College of Virginia
CAS Society: Association of Professors of Medicine
Undergraduate School: Yale University
Degree: B.A. Date: 1953
Medical School: Yale University Year Graduated: 1957

Location and Nature of Major Graduate Training:

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

Intern, North Carolina Memorial Hospital 1957-58

Assistant Resident, North Carolina Memorial Hospital 1958-59

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

Research Fellow, Yale University, 1962-63

Postdoctoral Research Fellow, Duke University, 1963-64

Board Certification:

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

Academic Appointments (With Dates):

Professor and Chairman - Medical College of Virginia, Dept. of Internal Medicine

Professor - University of North Carolina/North Carolina Memorial Hospital, Dept. of Internal Medicine

Societies/Affiliations:

See attached Sheet

Honors/Awards:

1968 - Research Career Development Award

1969-73 - Burroughs Wellcome Clinical Pharmacology Award

Alpha Omega Alpha

1981 - MCV Deans Award

1989 - Master, American College of Physicians

SOCIETIES/AFFILIATIONS:

Association of American Physicians 1985-to present

American Society for Clinical Investigation 1972-76

Association of Professors of Medicine 1982-88

Southern Society for Clinical Investigation 1971-76

American College of Physicians 1982-88

American Board of Internal Medicine 1979-87

National Digestive Diseases Advisory Board 1987-91

National Institues of Arthritis, Diabetes, Digestive & Kidney Diseases 1982-86

National Institutes of Health, Metabolism Study Section 1965-70

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: George A. Hedge, Ph.D.
Present Location (School) West Virginia University School of Medicine
CAS Society: American Physiological Society
Undergraduate School: University of Missouri

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

University of Missouri, M.A., 1963, Pharmacology

Stanford University, Ph.D., 1966, Physiology

Academic Appointments (with dates)

Assistant Professor, Department of Physiology, University of Arizona, College of Medicine, 1968-72

Associate Professor, Department of Physiology, University of Arizona, College of Medicine, 1972-77

Sabbatical Leave, Rudolf Magnus Institute, University of Utrecht, The Netherlands, July-Dec. 1975

Professor/Chairman, Dept. of Physiology, West Virginia University School of Medicine, 1977-present

Sabbatical Leave, Department of Histology, University of Lund, Sweden, Apr.-Sept. 1983

E.J. Van Liere Professor and Chmn., Dept. of Phys., West Virginia. Univ. Sch. of Med., 1985-present

Societies/Affiliations:

American Physiological Society, Endocrine Society, International Society of Neuroendocrinology, Association of Chairmen of Departments of Physiology, American Thyroid Association, Society for Neuroscience

Honors/Awards:

~~MacLachlan Award for Teaching Excellence, West Virginia University Medical School~~ (1980/81)

~~Fulbright Research Scholar in Sweden (1983)~~

~~Visiting Professor, National Science Council of Taiwan (1983)~~

~~Edward J. Van Liere Professorship, West Virginia University School of Medicine (1985)~~

~~Faculty Appreciation Award, West Virginia University School of Medicine Alumni Association~~ (1987)

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Barbara J. McLaughlin, Ph.D.
Present Location (School) University of Louisville School of Medicine
CAS Society: American Society for Cell Biology
Undergraduate School: University of Florida

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

University of Wisconsin (Visiting Graduate Student, Anatomy, 1969-1971)

Stanford University, Ph.D., Anatomy, 1966-1971

University of Cambridge (Postdoctorate, Zoology, 1971-1973)

Academic Appointments (with dates)

Assistant Professor of Anatomy	(1974-1976)
Associate Professor of Anatomy	(1976-1983)
Professor of Anatomy & Neurobiology	(1983-1987)
Professor/Ophthalmology	(1985-1987)
Professor/Ophthalmology & Visual Sciences	(1988-present)

Societies/Affiliations:

American Society for Cell Biology

American Association of Anatomists

Society for Neuroscience

Association for Research in Vision & Ophthalmology

Honors/Awards:

NIH-NEI Visual Sciences A-Z Study Section (1985-1989)

NIH-NINCDS Behavioral Neurosciences Study Section (1984-1985)

NIH-NINCDS Neurological Disorders Program - Project Study Section (1978-[illegible])

AAA Executive Committee (1988-1992)

NIH-NEI Reviewers Reserve (1989-1993)

NOMINEES FOR CAS ADMINISTRATIVE BOARD
CV FORM

Name: Thomas C. King, M.D.
Present Location (School) Columbia University College of Physicians and Surgeons
CAS Society: American Association for Thoracic Surgery
Undergraduate School: Utah; University of Missouri
Degree: BS MA Date: 1950, 1963
Medical School: Utah Year Graduated: 1954

Location and Nature of Major Graduate Training:

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

Intern in Surgery, Presbyterian Hospital, New York 1954-5

Resident in Surgery, University of Utah Hospitals, Salt Lake City, 1955-59

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

Cardiothoracic Surgery, Utah, 1960

Board Certification:

Surgery, 1960 (Specialty/Date)

Thoracic Surgery, 1962 (Specialty/Date)

Academic Appointments (With Dates):

Assistant Professor, Univ of Kansas, 1960-64

Associate Professor, University of Illinois, 1964-66

Professor, University of Utah, 1967-72

Professor, Columbia University, 1973 - present

J. M. Ferrer Professor, Columbia University, 1983 - present

Societies/Affiliations:

American Association for Thoracic Surgery, American Surgical Association, Society of University Surgeons, Society for Critical Care Medicine, Societe Internationale de Chirugia, American College of Surgeons (Fellow)

Honors/Awards:

Norman Paul Professor, University of Sydney, Australia, 1973

AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

October 2, 1989

MEMORANDUM #89-62

ACTION

To: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

From: Robert G. Petersdorf, M.D.
President

Subject: Proposed NIH/ADAMHA Guidelines on Conflict of Interest in Research

****
* The NIH and ADAMHA have proposed guidelines concerning conflicts of interest in *
* research. In order for the AAMC to prepare a response fully representative of *
* the concerns of its constituency, it will be critical to have member input. Therefore, *
* we are requesting that you review the proposal attached and communicate your views *
* and comments to the AAMC by November 1. *
****

In the September 15 edition of the NIH Guide for Grants and Contracts, the NIH and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) proposed new guidelines on conflict of interest for investigators funded by those two agencies (attached). Comments on the proposal will be accepted by NIH until December 15.

The issue of conflicts of interest in research is a particularly complex one, ever more so as university-industry relationships continue to flourish. It appears that both academic institutions and their faculty are creating links with industry at an unprecedented rate and the forms these relationships take are quite diverse. Also, a recent review of the conflict of interest policies of our member institutions reveals that, although the majority of our schools have or are developing relevant policies, quite varied approaches have been taken in dealing with this subject.

In light of the diversity and complexity of the issue, it will be critical for the AAMC to have input from its membership so that a response that fully addresses the concerns of its constituency can be prepared.

The Proposal

The existing PHS Grants Policy Statement already requires that recipient institutions have conflict of interest policies addressing financial interests, gifts, gratuities, favors, and nepotism, among other areas. The new proposal was developed to "provide further guidance" and "greater detail" to the current requirements. Some examples of newly stated requirements that merit particular attention include the following:

- The proposal would specifically prohibit those directly involved in NIH- or ADAMHA-funded research, or their immediate families, from having personal equity holdings or options in any company that would be affected by the outcome of the research, including companies sponsoring product or equipment evaluations.

- Research personnel would also be forbidden from receiving honoraria, fees for service, or a management position from the aforementioned sponsors. Neither prohibition is absolute, however, as the grantee institution would be allowed to grant waivers.

- Individuals in a position to make decisions concerning NIH- or ADAMHA-supported projects would have to disclose all financial interests and professional activities to their institution at the time of submitting a research proposal.

- Sharing information and research-products derived from NIH- or ADAMHA-funded research with "any company with which a conflict exists" would be prohibited, unless the information or research products are made publicly available.

- Commercial co-funding of research would have to be disclosed on relevant research applications and proposals.

- NIH or ADAMHA, as relevant, would have to be notified immediately when a conflict of interest situation is identified. However, it is not clear what situations would necessitate such notification; the term "conflict of interest" is in fact never defined in the proposal. The proposal notes that the agency notified might permit the conflict to exist if it determines that this is in the best interest of the public and of NIH or ADAMHA.

- Failure on the part of the institutions to meet the requirements of the proposal "could affect funding."

Your comments on these specific aspects of the proposal, as well as on the proposal as a whole, should be sent by November 1 to Mr. Allan C. Shipp, Division of Biomedical Research, Association of American Medical Colleges, One Dupont Circle, Suite 200, Washington, D.C. 20036. If you have any questions, please feel free to contact Mr. Shipp at 202/828-0484.

NIH GUIDE FOR GRANTS AND CONTRACTS

Volume 18 No. 32, September 15, 1989

REQUEST FOR COMMENT

ON

PROPOSED GUIDELINES

FOR POLICIES ON CONFLICT OF INTEREST

developed by

THE NATIONAL INSTITUTES OF HEALTH

and

THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

The National Institutes of Health (NIH) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) seek comments from the public on the following draft issuance, intended to protect against conflicts of interest related to NIH- and ADAMHA-supported research. The NIH and ADAMHA are particularly interested in receiving comments on issues presented below from individual researchers, scientific societies and associations, independent science advisory bodies, members of Congress, other Federal agencies that support or conduct research, and institutions that receive funds from NIH or ADAMHA to conduct or support biomedical or behavioral research. Interested individuals and parties are encouraged to submit their comments by December 15, 1989.

Please address your comments in writing to: Dr. Katherine L. Bick, Deputy Director for Extramural Research, Shannon Building, Room 144, 9000 Rockville Pike, Bethesda, Maryland 20892. For further information, please contact Dr. Bick at (301) 496-1096.

BACKGROUND:

The section of the PHS Grants Policy Statement on Standards of Conduct for Employees (of Grantee Organizations), page 55, provides that, "Recipient organizations must establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial

gain for themselves or others such as those with whom they have family, business, or other ties. Therefore, each institution receiving financial support must have written policy guidelines on conflict of interest and the avoidance thereof. These guidelines should reflect State and local laws and must cover financial interests, gifts, gratuities and favors, nepotism, and other areas such as political participation and bribery. These rules must also indicate the conditions under which outside activities, relationships, or financial interests are proper or improper, and provide for notification of these kinds of activities, relationships, or financial interests to a responsible and objective institution official." It also sets forth an outline of what those rules of conduct must contain, namely "a provision for prompt notification of violations to a responsible and objective grantee official, and must specify the type of administrative action that may be taken against an individual for violations."

The purpose of this draft issuance is to provide further guidance for the extant PHS Grants Policy Statement and to provide greater detail to the stated policies of the current guidance. It is formulated to assist institutions who receive support for biomedical or behavioral research from the NIH or ADAMHA to establish acceptable criteria for their own conflict-of-interest policies. Institutions that receive such funds are expected to adopt policies that build upon this framework and that reflect their specific needs. Signature of the responsible institutional official on the application or proposal constitutes certification that the institution either has formulated, enacted, and is enforcing such policies, or will do so no later than the date of any award.

NIH- and ADAMHA-supported investigators appear to be involved increasingly in non-Federally supported activities. This situation represents some obvious philosophical and potential practical advantages, including rapid technology transfer and cooperative research ventures that facilitate efficient exchange of research results from the research laboratory or clinical trial to utilization in the private sector. With the increased involvement of NIH- and ADAMHA-supported investigators in non-Federally supported activities, particularly those sponsored by industry, have come some complex questions. Intense competition for Federal research funds, often resulting in partial funding for some research projects, also has stimulated or required investigators to seek additional research funding from non-Federal sources. In addition, recent research advances in biomedical science have produced major opportunities for commercialization of research findings.

The establishment and maintenance of a healthy research environment in which innovation flourishes clearly depend on the integrity and objectivity demonstrated by individual investigators, other individuals associated with research projects, and recipient institutions. This draft issuance was developed with those goals in mind. The intention in formulating them is to ensure that NIH- and ADAMHA-supported research is carried out in a completely objective manner, and that research results are not influenced by the possibility of financial gain.

These proposed guidelines should not stifle research creativity or technology transfer from the research laboratory to commercial use but, rather, provide guidance concerning the safeguards needed to ensure unbiased performance and reporting of research results. Such safeguards are particularly important for situations in which conflicts of interest exist but are not publicly discernible. The proposed guidelines do not apply to research supported under the Small Business Innovation Research Program, established by the Small Business Innovation Development Act of 1982 (P.L. 97-219). This Act was intended to increase the involvement in research and development of small, innovative firms by making Federal research and development funds more readily available to them, so that they may participate more fully in technological innovation and in strengthening the economy.

On June 27 and 28, 1989, NIH and ADAMHA sponsored an open meeting to discuss issues related to the problem of conflict of interest. Discussion at that meeting addressed a number of issues that have served as a basis for this draft issuance. There was general agreement that institutions that receive biomedical research funds from the NIH or ADAMHA should develop their own policies with respect to conflict of interest. NIH and ADAMHA have developed the proposed guidelines in this document to serve as a point of departure for further discussion on procedures for ensuring high integrity in the performance, reporting, and utilization of research results, and in the appropriate use of public funds for public purposes.

We request comments on the proposed guidelines that are presented below. We also request specific comments on the following questions, as well as on any other issues related to conflict of interest.

What policies does your institution already have in place to deal with conflicts of interest? How does this draft issuance compare with them?

How should information be disseminated regarding conflict-of-interest policies?

What is your perception of the impact of your institution's adoption of policies, based on the framework presented here, on your own research or, more broadly, on basic biomedical research, clinical trials, technology transfer, product development, and commercialization of research results?

Proposed Policy

Research activities supported by NIH or ADAMHA must be conducted in an objective manner, free of any potential for undue influence arising from the private financial interests of those responsible for the conduct of the research. Public funds must be expended to advance public purposes, in this case, the conduct of biomedical and behavioral research. Private financial interests can adversely affect the accomplishment of this public purpose by directly affecting the manner in which the research is conducted, by creating the appearance that the research has been influenced by those financial interests, or by inhibiting the dissemination of research results.

Recipients of research funds are responsible for ensuring that the funds are expended for the public purposes for which they were awarded. As part of this responsibility, recipients must adopt procedures that will prevent the research from being influenced or potentially influenced by the private financial interests of those responsible for the conduct of research. The following proposed guidelines establish minimum standards for the procedures to be adopted by recipients, including identification of those financial interests which are incompatible with the need to ensure that publicly funded research is conducted objectively.

I. PROPOSED RESPONSIBILITIES OF NIH AND ADAMHA, AWARDEE INSTITUTIONS, AND INDIVIDUALS:

A. NIH and ADAMHA:

The NIH and ADAMHA are responsible for formulating and disseminating conflict-of-interest guidelines to assist institutions to develop their own conflict-of-interest policies. The NIH and ADAMHA also are responsible for:

In specific instances, reviewing institutions' conflict-of-interest policies.

Routinely reviewing actions that the institutions have taken with respect to waivers and exceptions.

Assuring that the necessary terms and conditions are discharged satisfactorily prior to making an award. In the absence of fulfillment of the necessary terms and conditions, funding may be affected.

B. Awardee Institutions:

Institutions that receive NIH or ADAMHA funds are responsible for establishing and implementing policies and procedures in accord with this draft issuance. Upon request, institutions shall provide copies of their policies and procedures and information regarding their implementation to the appropriate NIH or ADAMHA officials. The institutions also are responsible for:

Maintaining records of disclosures made and actions taken regarding persons associated with any NIH or ADAMHA award for a period of at least three years beyond the termination of that award.

Promptly notifying the funding agency if they identify any practice or situation involving a conflict of interest which could potentially affect one or more NIH or ADAMHA-supported projects.

Resolving any failure to comply with these proposed guidelines prior to accepting an award.

Policies.

Each institution that applies for assistance to the NIH or ADAMHA for any project or program that involves the conduct of biomedical or behavioral research shall certify by the institutional signature on its application or proposal that it has institutional policies in place that are in accord with this draft issuance or will have such policies in place no later than the date that any award would be accepted.

Institutions are encouraged to adopt policies that build upon this framework and that reflect their specific needs and situations.

Education.

Institutions are expected to establish a means of informing all investigators applying for or receiving funding from the NIH or ADAMHA, as well as all relevant research employees,

consultants, and administrative staff at that institution who are in position to make decisions about or to affect the outcome of the research, of the institutional policies covering conflicts of interest. This information should include, at a minimum, identification of prohibited financial interests, disclosure procedures, and sanctions for non-compliance.

C. Individuals:

These proposed guidelines apply to all investigators, key employees, consultants, and persons with primary management, advisory, or supervisory responsibilities for NIH- or ADAMHA-funded research, and all persons who are in a position to have a critical influence on, or substantive control over, that research. Those persons are responsible for avoiding circumstances that would put them in a conflict-of-interest situation with that research. These provisions also apply to the spouses, dependent children, and other dependents of the individuals mentioned above.

Full disclosure of all financial interests and outside professional activities, by all who are in a position to make decisions concerning one or more NIH- or ADAMHA-supported projects, shall be made to the institution at the time a research application or proposal is submitted to the NIH or ADAMHA. This shall include the financial interests of their spouses, dependent children, and other dependents. These disclosures shall be updated to the institution annually.

All individuals for whom these proposed guidelines apply shall comply with the conflict-of-interest policies of the institutions through which the NIH or ADAMHA funding is provided and shall report immediately any conflicts of interest to the appropriate institutional officials.

II. DISCLOSURES:

Full disclosure of all funding other than that from the applicant institution is required of all personnel of awardee institutions as described above who are currently involved in, or currently applying for, research funds from NIH or ADAMHA. This disclosure includes support for laboratory activities, special instrumentation or other products, services, consultancies, honoraria, and other benefits.

All disclosures and waivers shall be reviewed at the institution in a timely manner by knowledgeable and objective

individuals appointed by institutional officials. In order to assure timely and objective evaluations, institutions may wish to appoint a panel of at least 3 members, one of whom has no institutional affiliation and one of whom is the institutional official responsible for signing the grant application or contract proposal.

Confidentiality shall be maintained at all times unless that confidentiality would interfere with the interests of the institution or the Federal Government.

Institutions may grant waivers in unusual situations when it can be demonstrated that the financial interest is so insignificant that it would not compromise the objectivity of the research results or the interests of the Federal government or the public. The NIH or ADAMHA shall be informed within thirty days of any such waiver granted to an individual involved in any way with a NIH- or ADAMHA-funded project related to the waiver.

If a conflict-of-interest situation is identified that involves one or more NIH- or ADAMHA-supported project(s), the NIH or ADAMHA and appropriate institutional official(s) shall be notified immediately, and the institution shall take immediate steps to safeguard Federal funds until such time that the conflict-of-interest situation is eliminated.

Disclosure information shall be updated to the institution at least once per year. Changes that could reflect possible conflicts of interest should be reported immediately to the responsible institutional official(s).

The institution shall maintain records of disclosures, waivers, and of all actions in response to review of disclosures for personnel associated with NIH- or ADAMHA-supported projects for a period of three years after the termination of that project.

III. PROHIBITED SITUATIONS:

Institutions may establish their own policies on prohibited situations. However, the following are basic standards for all institutions.

1. No investigator, key employee, consultant, or other persons with primary research, management, advisory, supervisory, or purchase authorization responsibilities, or their spouses, dependent children, or other dependents, shall be allowed to have

personal equity holdings or options in any company that would be affected by the outcome of the research or that produces a product or equipment being evaluated in the research project. This does not apply to equipment or products that are commonly found in research laboratories, such as commercially available centrifuges, pH meters, and common reagents. This prohibition does not include blind trusts, diversified mutual funds, or other financial interests over which the individual investor has no discretionary control. The institution may grant a waiver to this requirement if it determines that such holdings are so insignificant they do not have the potential of influencing research results or the direction of the research.

2. Information and/or research products derived from NIH- or ADAMHA-funded studies shall not be shared with any company with which a conflict exists unless or until the information or research products are made publicly available.

3. Specific requirements shall apply if an investigator, key employee, consultant, or other involved person receives funds from NIH or ADAMHA as well as commercial funding, for any of their research, as follows:

> All research funding for all research projects must be disclosed as required in the appropriate sections of applications and proposals to the NIH or ADAMHA (under the "Other Support" section), as well as to the institutional official(s) responsible for conflict-of-interest review.
>
> Institutional conflict-of-interest reviews need to be particularly careful to ensure that private companies are not in a position to influence the research plan, results, or the reporting or interpretation of results of NIH- or ADAMHA-supported research.

An investigator, key employee, consultant, or other involved person may not receive honoraria, fees for service, or a management position from a private source if that individual is involved in an NIH- or ADAMHA-supported project that is evaluating or testing a product of the source. Honoraria, fees for service, or management positions from other sources are allowed provided that their acceptance does not jeopardize the recipient's objectivity with respect to the NIH- or ADAMHA-supported project or result in special access to information that is not publicly available, and that full disclosure is made to designated institutional officials. For example, care must be taken to ensure that the private company has no role in any decisions that would impede the standard practices for the publication or other dissemination of research results related to NIH- or ADAMHA-supported research.

IV. CRITERIA FOR WAIVERS AND EXCEPTIONS:

The institution may grant waivers in certain circumstances if it determines that such holdings do not have the potential for influencing research results, the reporting of research results, the direction of the research, or putting the individual in a situation of being able to derive special advantage because of information he/she has available through the NIH/ADAMHA research results.

All waivers and exceptions shall be reported to the Deputy Director for Extramural Research, NIH, if they relate to NIH-supported projects, or to the Associate Administrator for Extramural Programs, ADAMHA, if they relate to ADAMHA-supported projects, prior to accepting an award or, if disclosure is made after the award, within thirty days of granting the waiver or exception.

The NIH or ADAMHA may allow a conflict-of-interest situation to exist if it has been reported to NIH or ADAMHA and the agency determines that this is in the best interests of the public and of NIH or ADAMHA.

V. REMEDIES:

If situations involving a conflict of interest related to NIH- or ADAMHA-supported research are discovered, the awardee institution has the first responsibility to resolve the problem. If the institution does not resolve the problem in a timely manner, then the NIH or ADAMHA will take action.

Awards will be made without prejudice if prohibited conflict-of-interest situations are rectified prior to the award date.

Institutions are required to notify the funding agency immediately if prohibited conflict-of-interest situations are detected or develop after awards have been made and the conflict is not resolved promptly.

NIH or ADAMHA may include special terms and conditions in an award if (1) an institution is not complying with these proposed guidelines or (2) to resolve a conflict-of-interest situation that has not been resolved by the institution. Failure on the part of the institution to meet these special terms and conditions could affect funding.

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

October 13, 1989

MEMORANDUM

TO: Council of Academic Societies

FR: Addeane Caelleigh, Editor, Academic Medicine

The reorganization of the AAMC's journal is completed, and in January 1990 we begin the journal's 65th volume and Academic Medicine's first anniversary. Now that the dramatic changes of design and format are firmly in place, we can continue our efforts to refine and improve the journal's content. By the end of 1989 we will have a wide range of articles, two supplements, and a special theme issue. The supplements were on international medical education and on ambulatory care training in VA facilities; the special theme issue, which will appear in December, is on medical ethics education.

You will soon have complimentary subscriptions of Academic Medicine. Beginning in January 1990, the two designated CAS representatives will receive free subscriptions as part of the societies' benefits from AAMC dues payment. For newly appointed representatives, the subscriptions will begin the month after the CAS office has been notified of the representative's appointment. The complimentary copies will end when the representative's term ends. I hope you will look at Academic Medicine carefully and will offer suggestions.

In that light, I ask you to fill out the Academic Medicine questionnaire in your briefing book. It is short and designed to draw out your opinions and suggestions for upcoming issues of the journal. Please identify yourself on the questionnaire so that we can discuss your ideas with you.

I want to thank the CAS members who have helped us during the tough and exciting transition in 1989, and I hope to support the work and goals of CAS societies in future issues of Academic Medicine.

Academic Medicine Questionnaire

AAMC Council of Academic Societies

1989 Annual Meeting

What do you think are the three most important health policy issues that Academic Medicine should publish articles about?

What do you think are the three most important educational issues facing your specialty or discipline?

What do you consider the most important problem confronting your specialty or discipline as a whole?

Do you have specific suggestions for authors and topics of major "front" articles in Academic Medicine?

_____

Name (please print)

AAMC FACULTY ROSTER SYSTEM

Background

One of the services provided by the AAMC to its member institutions is the collection and management of information about medical school faculty members. This information is used by the AAMC and the medical schools for research and human resource planning.

The Faculty Roster began in 1966 as an annual survey of faculty characteristics. It has evolved over the years from an annual survey to a continuously updated database. The information is provided by Faculty Roster representatives at the schools or by the faculty members themselves. The data are edited and entered into the database by AAMC staff. This allows the AAMC to serve the schools with up-to-date reports and to use current faculty data in national health manpower studies.

Data from the Faculty Roster are used primarily in aggregate form for analyses conducted by the AAMC staff. Individual records may also be released, with consent, to federal agencies seeking consultants and to medical school search committees. Although the information in the database is not particularly sensitive, the AAMC takes care to protect faculty members' privacy.

Records are maintained for all full-time salaried faculty at 126 participating AAMC member schools. As of June 1988, the Faculty Roster database contained data on 60,534 active faculty and 69,968 former members of medical school faculties.

The project has been supported since its inception by the National Institutes of Health.

Services

The AAMC provides certain routine computer-generated reports to its member institutions at no charge. These routine reports include:

- LCME accreditation data.
- Data for use in completing the LCME annual questionnaire.
- Annual alumni reports for both MDs and PhDs.

The following reports are also provided on request at no charge:

- Rosters of faculty by department.
- Frequency distribution of faculty by department, sex, ethnic self-description, and degree.

The following items are available on request at cost:

- Recruitment assistance in the form of lists of medical school faculty members meeting the requirements for a specified position.
- Women and Minorities on U.S. Medical School Faculties, 1988, now an annual report, the most recent in a series of reports on the nationwide representation of women and minority ethnic groups on medical school faculties.
- Computer tapes or flexible discs containing data on the requesting school's faculty.
- Other special reports as needed.

Users

The users of Faculty Roster information and services include:

- o Faculty Roster representatives at participating schools.
- o Alumni organizations.
- o Medical school deans, department heads, and administrative staff.
- o Medical and professional organizations.
- o Federal agencies.

Workshops

The Faculty Roster staff conducts workshops for Faculty Roster representatives throughout the U.S. These workshops review reporting procedures, provide a forum for discussions of reporting problems, and inform the representatives about the various administrative and research uses of the data.

Data

Identifying information:

- o Name
- o Sex
- o Date of birth
- o Ethnic self-description

Current Appointment Information:

- o Medical School
- o Department
- o Academic rank
- o Joint appointment
- o Employment location
- o Major areas of responsibility

Professional Training and Experience:

- o Employment history
- o Research training
- o Institution, field of study, and year of each advanced degree
- o Medical specialty and board certification

The database offers space for 16 characters of optional information about each faculty member. This space may be used to meet the specific needs of member institutions. Several schools use this space to record dates of tenure review, tenure award, or retirement.

For further information, contact:
Brooke Whiting, Ph.D.
Director, Faculty Roster System
AAMC
One Dupont Circle NW, Suite 200
Washington, D. C. 20036
Telephone: 202-828-0650

FACULTY ROSTER SYSTEM
RECRUITMENT ASSISTANCE

Background

In 1979, the AAMC Faculty Roster System created an index of women and underrepresented minority faculty members for the purpose of assisting constituents in recruitment. Specifically, this index was used by AAMC staff to assist medical schools in identifying potential candidates for vacant senior faculty positions and to aid federal agencies in identifying women and minorities to serve as consultants and members of advisory groups.

At that time, only women and minority faculty members were asked to sign a release form, allowing or objecting to the use of their Faculty Roster records for this purpose. In 1980, the release form was made available to all faculty.

Since 1980, the Faculty Roster System has provided recruitment assistance as a service to its constituents. Many schools have made frequent use of this service. In many cases, these schools have come to view it as an essential element in the recruitment process, generating numerous requests (more than 200 yearly) for custom rosters of potential faculty applicants.

Although recruitment assistance was originally implemented as a means of placing women and minority faculty, it is no longer limited to these groups. Search committees are now requesting names of white males as well in their recruitment efforts. And, although searches are now limited to established faculty positions, we hope to add residents and fellows to the Faculty Roster database in the future, thus including entry level candidates in searches.

Procedure

Recruitment assistance can be obtained promptly by following a simple procedure. Upon receipt at AAMC of a written request describing a faculty vacancy, a selection is drawn from the records in the Faculty Roster database, matching the search committee's given criteria.

- The database contains records for approximately 95% of all active full-time U.S. medical school faculty members.
- If a position's criteria include special considerations such as ethnicity and sex, the listing provided by Faculty Roster can be created to meet them.

When formulating a position description, it is helpful to keep in mind the following:

- Be as specific as possible. Be sure to include degree, rank, specialty (or field of study) and board certification/eligibility.
- A very narrow set of criteria may result in a short list.
- Overly broad criteria may result in hundreds or even thousands of potential candidates.

Upon receipt of the qualified faculty members' records, you must then contact those individuals who appear to meet your criteria to determine whether or not they wish to apply for the position.

To avoid delay, please send payment or a purchase order with your request.

Format

Recruiting information is available in two forms:

- DISPLAY FORMS. A package of "display forms," each form containing an individual's complete Faculty Roster record. Each record includes:
  - Demographic data
  - Current appointment data
  - Employment location
  - Employment background
  - Degree information
  - Graduate medical training history
  - Medical specialty/Board certification

  Cost: $50 per package per departmental search

- LISTING. A condensed listing of qualified individuals' names and addresses; this listing includes faculty members' ethnicity, sex, rank, degree, specialty or field of study, board certification data, and year of first medical school faculty appointment.

  Cost: $50 per list per departmental search

With either format you select, you may also purchase mailing labels for potential candidates at $10 per set. Please be sure to indicate that you would like mailing labels with your request.

Users

The users of Faculty Roster recruitment assistance information include:

- Affirmative Action officers
- Search committees
- Personnel administrators
- Faculty special interest groups
- Government agencies

For further information, please contact:

Ms. Lisa Sherman
Research Assistant
Faculty Roster System
AAMC
One Dupont Circle NW, Suite 200
Washington, D. C. 20036
202-828-0611

The Faculty Roster System is supported in part by the National Institutes of Health.

COUNCIL OF ACADEMIC SOCIETIES
SPRING MEETING

March 14-16, 1990
Hilton Palacio Del Rio
San Antonio, Texas

PRINCIPLES OF PROFESSIONAL DEPORTMENT IN ACADEME
PRELIMINARY PROGRAM OUTLINE

Wednesday, March 14, 1990

11:00 a.m. - 12:30 p.m.	CAS Administrative Board Meeting
12:30 - 1:30 p.m.	Luncheon
1:30 - 3:30 p.m.	Orientation for new CAS Representatives
6:00 - 7:00 p.m.	Keynote Address Barbara J. Culliton, Science Magazine
7:00 - 7:30 p.m.	Reception
7:30 - 9:30 p.m.	Banquet

Thursday, March 15, 1990

8:00 a.m.	Continental Breakfast
8:30 - 8:45 a.m.	CAS Chairman's Address
8:45 - 10:00 a.m.	"Managing the Mixed Message: Maintaining Academic Values v. Encouraging Entrepreneurism"
10:00 - 10:15 a.m.	Coffee Break
10:15 - 10:30 a.m.	Report from the AAMC Ad Hoc Committee on Misconduct and Conflict of Interest in Research
10:30 - 11:15 a.m.	Charges to the Discussion Groups
11:15 a.m. - 12:30 p.m.	Discussion Groups: "Academic Deportment in a Competitive Entrepreneurial Clinical Environment" - Myron Genel, M.D. and Thomas King, M.D. "Responsibilities in Training and Education" - Rita Charon, M.D. and Robert O. Kelly, Ph.D. "Deportment of Department Chairs and Section Chiefs" - S. Craighead Alexander, M.D. and Kenneth Berns, M.D., Ph.D. "The Role of Academic Societies in Developing Codes of Conduct" - Paul Friedman, M.D., and Barbara McLaughlin, Ph.D.
5:00 - 6:00 p.m.	Reports from the Discussion Groups

6:00 - 6:30 p.m.	President's Report - Robert G. Petersdorf, M.D.
6:30 - 7:00 p.m.	Legislative Update - Richard Knapp, Ph.D.
7:00 - 8:00 p.m.	Reception
8:00 - 10:00 p.m.	Dinner Cruise

Friday, March 16, 1990

8:00 a.m.	Continental Breakfast
8:30 a.m. - 1:00 p.m.	CAS Business Meeting
1:00 - 2:30 p.m.	CAS Administrative Board Luncheon

September 27, 1989

AAMC

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COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

ISSUE UPDATE

(Prepared by the AAMC Division of Biomedical Research)
(New developments are in bold italics)

1. Animal Welfare

The Association is a strong advocate of the necessity of using animal models in research. Influential and well funded organizations opposing the use of animals have necessitated a constant vigilance over this issue. The Division monitors these activities through collaboration with the National Association for Biomedical Research (NABR) and participation in the Washington Area Research Network (WARN).

On March 15, the Animal and Plant Health Inspection Service (APHIS) of the USDA proposed new amendments to the Animal Welfare regulations (9 CFR Parts 1,2 and 3). The amendments to Parts 1 and 2 of the regulations, which address definitions and administrative requirements respectively, were originally published in 1987 and were revised and republished as new proposals. Many Part 3 proposals, addressing standards for cage sizes, social living conditions and enhancements to the physical environment of research animals, appeared for the first time.

On May 12, the Association submitted its letter of comment to Parts 1 and 2 of the regulation, objecting to APHIS' desire to limit comment to the interrelationship of Part 1 and 2 with Part 3, the extent to which the proposal exceeds the statutory intent of the Animal Welfare Act, its excessively prescriptive approach and its continued inconsistencies with Public Health Service (PHS) requirements. The letter concluded with a line-by-line analysis of the proposal. ***On July 11, comments on the Part 3 of the rule were submitted and addressed, among other things, the undesirability of imposing minimum housing and handling standards through regulation where guidelines would be more appropriate.***

Of great concern to regulated institutions were the cost implications of complying with these unnecessarily complex and burdensome regulations. The AAMC, in collaboration with NABR, sent a survey to its constituency to assess their financial impact. The AAMC survey and a survey conducted by the Pharmaceutical Manufacturers Association (PMA) suggested that APHIS underestimated the total impact by 100 percent.

On August 31, the <u>final</u> rules for Parts 1 and 2 were published (54 Federal Register 36112-36163). The final version of the <u>new</u> Part 3 requirements (as last proposed in March 1989) may not appear for another six months to one year. Until that time, APHIS indicates that Parts 1 and 2 can be fully implemented with the existing Part 3 standards.

As a result of public comment and considerable collaboration with the Public Health Service (PHS) and the

Interagency Research Animal Committee (IRAC), Parts 1 and 2 have been significantly revised, reorganized, and improved when compared to the March 1989 proposal. Many of the Association's concerns were addressed, including deletion of numerous burdensome reporting and recordkeeping requirements. Many overly prescribed duties for the institutional animal care and use committee (IACUC) and the attending veterinarian were also deleted from the rule in recognition that "research facilities should be accorded greater flexibility in determining how best to ensure compliance." Perhaps most significant is the degree to which the rule is now coordinated with the PHS Policy on the Humane Care and Use of Laboratory Animals, which outlines requirements to be met by institutions receiving PHS support for research (virtually all 127 AAMC member medical schools). Still required by the final rule is open access to the research facility by APHIS inspectors who may examine and make copies of records and photograph conditions. Although many in the research community were concerned about breaches of confidentiality and security that might occur when such information is obtained though Freedom of Information Act requests, APHIS argues in the rule that it would not necessarily be "regular practice" to retain such documentation and therefore these records would not be "generally" available. Also remaining in the rule is IACUC authorization to review, approve or require modifications in proposed animal care and use procedures. The same provision is found in the PHS policy, though APHIS' statutory authority for administering this requirement has often been questioned by the research community.

The research community has also repeatedly voiced concern about the lack of justification for, the requirements relating to the exercise of dogs and the promotion of the psychological well-being of nonhuman primates. Previously, Part 2 proposed that detailed records be kept to document the time and length of exercise periods and human interaction. APHIS continues to stand by this approach but will consolidate all requirements related to these provisions in the forthcoming final version of Part 3. Until Part 3 appears as a final rule, the relevant recordkeeping proposals will not be in effect.

Regarding the cost impact, APHIS acknowledged in the final rule that its efforts to quantify the financial impact were constrained by available time and resources and that the cost estimates were not to be construed as "exact estimates of compliance due to obvious limitations." APHIS believes the AAMC and PMA estimates (as reported by NABR) represent "a 'worst case' scenario."

Readers should note that at the 1989 AAMC Annual Meeting in November, the CAS will be sponsoring a plenary session titled, "In Defense of Animal Research: Models for Effective Action." Speakers will discuss models of successful actions by academic institutions, states, professional and voluntary societies, and NABR. The CAS Chair will summarize these actions, synthesize the discussion period and lay out a future CAS agenda.

2. Association of American Universities Report on Indirect Costs

The Association of American Universities (AAU) Ad Hoc Committee on Indirect Costs released in December 1988 a draft report titled, Indirect Costs Associated with Federal Support of Research on University Campuses: Some Suggestions for Change. As the title indicates, this report recommends numerous changes in federal policies concerning the recovery of indirect costs on federally-supported research, including (but not limited to):

- *Splitting the indirect cost rate into two new rates which are additive: a facilities and equipment rate, and a rate for all other components,*
- *The establishment of threshold rates for the administrative, library and student service costs components of the indirect cost rate, which could be claimed without further documentation,*
- *Encouragement of negotiated multiple-year rates,*
- *Charging more costs directly, and*

- *Greater uniformity in what is included in the base of direct research expenditures.*

Cornelius Pings, Provost of the University of Southern California, and Committee chair, presented the report's recommendations at the June 1989 meeting of the AAMC advisory boards. The AAMC has since been requested to respond to that report, and thus distributed it to all three governance councils for input. A draft response has been prepared and will be presented at the September 1989 advisory board meeting for review and consideration.

3. Conflict of Interest in Research

On June 27 and 28, NIH and ADAMHA held a forum on various facets of conflicts of interest in research. This meeting served as a precursor to the issuance by those agencies of draft guidelines dealing with this subject. Division Vice President Thomas Malone, Ph.D., spoke at that meeting on institutional oversight, stating that it is the obligation of the university to develop conflict of interest policies and to assure their effective implementation. He concurred with other speakers in viewing disclosure as the principal instrument of oversight and said he believed federal agency review of disclosures to be inappropriate. There was also general consensus by speakers and attendees that the appropriate locus of policy development and oversight is the university, not the federal agencies. Most representatives of academic institutions said they were comfortable with NIH and ADAMHA implementing for conflict of interest the same kind of assurance mechanism that was in place at that time for scientific misconduct policies. Speakers differed significantly on their views over the advisability of specific faculty activities, some firmly asserting that it was inappropriate for researchers to have financial interests in, or professional relationship with, companies producing drugs or devices under evaluation. Others contested this point, particularly with regard to consulting arrangements.

Pursuant to the conference, NIH and ADAMHA proposed in the September 15 edition of the NIH Guide for Grants and Contracts new guidelines on conflict of interest for investigators funded by those two agencies. The existing PHS Grants Policy Statement already requires that recipient institutions have conflict of interest policies addressing financial interests, gifts, gratuities, favors, and nepotism, among other areas. The new proposal was developed to "provide further guidance" and "greater detail" to the current requirements. For example, it specifically prohibits those directly involved in NIH- or ADAMHA-funded research, or their immediate families, from having personal equity holdings or options in any company that would be affected by the outcome of the research, including companies sponsoring product or equipment evaluation. Research personnel would also be forbidden from receiving honoraria, fees for service, or a management position from those sponsors. The prohibition is not absolute, however, as the recipient institution would be allowed to grant waivers.

The proposal would also prohibit the sharing of information and research-products derived from NIH- or ADAMHA-funded research with "any company with which a conflict exists," unless the information or research products are made publicly available. Also commercial co-funding would have to be disclosed on research applications and proposals. The proposal states that NIH or ADAMHA, as relevant, would have to be notified immediately when a conflict of interest situation is identified. However, it is not clear what situations would necessitate such notification; the term "conflict of interest" is in fact never defined in the proposal. The NIH Institutional Liaison Office reports that the notification requirement was intended to apply to prohibited situations. The proposal also notes that the agency notified might permit the conflict to exist if it determines that this is in the best interest of the public and of NIH or ADAMHA. Failure on the part of the institutions to meet the requirements of the proposal "could affect funding," the proposal states. Comments on the proposal will be accepted by NIH until December 15. In a memorandum being sent October 2, AAMC President Dr. Robert G. Petersdorf will be requesting comments from the Association's constituency and these will be incorporated into an AAMC response.

On a related note, the AAMC is developing a draft of a conflict of guidance document which is intended to aid institutions in the development of policies and procedures related to this issue. It will be reviewed

by the AAMC Ad Hoc Committee on Misconduct and Conflict of Interest in Research, now chaired by Michael J. Jackson, Ph.D., George Washington University School of Medicine Associate Dean for Research, on October 28. A final document should be available early in 1990.

4. Declining Autopsy Rates - Development of Integrated Postmortem Analysis Conferences

In response to concerns presented by the Association of Pathology Chairman, the AAMC has assembled a committee to examine the causes and consequences of the current, serious decline in the frequency with which autopsies are performed. Factors involved include cost, delay in reporting of findings, lack of coordination in presentation of findings, fear of malpractice and AIDS infection, the schedules of housestaff in the current DRG-reimbursement environment, and pressures to emphasize research in Pathology Departments. In view of the persistent value of the autopsy, both educationally and for quality-assurance, and because of the powerful interplay that can now be promoted between the autopsy and recent technology (especially radiological), the committee has begun preliminary exploration of a new format to encourage use of the autopsy. At present, it is not believed that traditional autopsy practices can be resurrected given all the prevailing counter-pressures. Rather, the committee envisions the design and promotion of a new format in which integration of pathological, radiological and other pre-and post-mortem information would be assembled on a regular, expedient schedule and presented and analyzed at regular Integrated Postmortem Analysis Conferences (IPACs). The Committee will continue to develop guidelines to promote the necessary interdisciplinary cooperation and public relations efforts which will be essential to success of this new approach.

5. Human Subjects Regulations

In a November 10, 1988 Federal Register notice, the federal agencies requested comment on a government-wide common rule relating to the use of human subjects in research. The Association commented on this rule, expressing concern over the following points: 1) The proposed model federal policy did not include the 60-day grace period, or time allowed an institution with an approved assurance to submit IRB approval of a project after submission of a grant application to an agency, which is found in Department of Health and Human Services (HHS) regulations. The Association argued that the grace period is essential to avoid unnecessary delays associated with the IRB certification process. 2) The model policy mandates institutions to have written procedures on handling scientific misconduct. With the rules proposed at that time on "Responsibilities of PHS Awardee and Applicant Institutions for Dealing with and Reporting Possible Misconduct in Science," the Association asked for a clear regulatory framework for this issue and stated that existing regulatory schemes, including the human subjects regulations, should be left undisturbed. 3) The Department of Education deviated from the common rule in asking for special representation on IRBs of persons concerned with the welfare of handicapped children and the mentally disabled. The Association argued that representation of the interests of vulnerable subjects is already provided for in the common rule and such emphasis on particular categories of subjects is unnecessary. 4) Lastly, the Association encouraged the Food & Drug Administration to adopt, wherever feasible, the assurance system as established for the other agencies of HHS.

As of this writing, the rule is still under consideration by OMB and the timing of its release in final form is uncertain.

6. Human Genome Initiative

For years, policy makers have debated the best means to approach federal efforts to map and sequence the human genome, or what is commonly referred to as the "human genome initiative." The debate focused principally on which agency should take the lead (NIH or the Department of Energy) and on questions of strategy (whether the effort was best conducted as a massive single undertaking by one laboratory or a

coordinated effort of numerous extramurally funded projects). Although DOE was most aggressive on this issue at the outset and continues to conduct related work, NIH has clearly emerged as the locus of the most visible coordinated U.S. effort.

Since those early discussion, an Office of Human Genome Research (OHGR) has been established at the NIH under the Office of the Director with a Program Advisory Committee. The FY 1990 President's budget proposal requested $100 million for the activities of this office, though $62 million seems a more likely appropriation based on the current appropriations bills. These figures compare to a total FY 1989 appropriation of $27.5 million. On June 22 of this year, HHS Secretary Louis Sullivan approved a proposal from then NIH Director James Wyngaarden to turn this office into a center with grant-making authority. The new "National Center for Human Genome Research" will replace the current OHGR on October 1. Its responsibilities will include, but not be limited to, 1) advising the NIH Director and senior staff on all aspects of genomic analysis, 2) coordinating the integration, review and planning of genomic analysis research, 3) formulating research goals and long-range plans with the guidance of the NIH Program Advisory Committee, 4) serving as a focal point on genomic analysis research with NIH and PHS, and 5) fostering national and international collaborations on this effort. The Office of Human Genome Research has also developed four working groups to examine 1) the possibility of developing center grants, 2) the needs for research training specific to this endeavor, 3) database requirements, and 4) ethical issues surrounding the information which would arise from sequencing and mapping efforts.

The Division monitors this initiative to assess its impact on funding priorities and opportunities at the NIH. The NIH was reluctant to take the lead on this initiative without assurance that it would not divert funds away from other vital programs. With appropriations dedicated to this purpose, it appears that these fears have been allayed. However, as the program expands, close surveillance of future funding priorities is merited.

7. Infectious Waste

As part of its surveillance of regulatory activities relating to the management of laboratory wastes, the Division has closely monitored the issue of infectious waste management. Public pressures, born of incidents of medical wastes washing on shore at public beaches, forced EPA to find a regulatory solution to this problem. Although this is largely perceived to be a clinically-oriented issue, EPA approaches to this problem have been so encompassing as to potentially include any laboratory or medical waste making contact with an infectious agent. In November 1988, President Reagan signed into law the Medical Waste Tracking Act (MWTA) of 1988 (P.L. 100-582) which required EPA to develop a demonstration tracking program to track medical waste from creation to disposal. Such a program was initially proposed in January of this year and the Association signed onto a letter with other organizations expressing concern over various issues, including the excessively broad categories of waste included in the program as proposed at that point.

Subsequently, in a March 24 Federal Register notice, the EPA proposed the new two-year trial program as an interim final rule becoming effective June 22. It requires hospitals, clinics, physician offices and other entities in the affected states that generate greater than 50 pounds per month of medical waste to record waste sources, transporters and destination on a four-part form signed by the carrier and the owner or operator of the disposal facility. Materials that must be tracked include cultures and stock of infectious agents; human blood and blood products; human pathological wastes; contaminated animal carcasses; wastes from patients with communicable diseases and used "sharps." The demonstration program originally applied to New York, New Jersey, Connecticut and seven states bordering the Great Lakes. However, the law permitted participating states to opt out of the program, provided they notified EPA by April 24, 1989, and allowed other states to petition to be included. New York, New Jersey and Connecticut were permitted to drop out only if they had programs in place which are as stringent as the federal one. ***All seven Great Lake***

states have elected not to participate in the program; Puerto Rico, Rhode Island, Louisiana and the District of Columbia initially indicated that they would voluntarily comply, but D.C. and Louisiana eventually reversed that decision.

The EPA notes in the rule that the tracking program "...may have only a limited effect on reducing beach wash-ups." It cites a New York Department of Environment Conservation study that found that most of these wastes do not, in fact emanate from hospitals, but rather from many other sources, including household waste and improper transport and handling of all kinds of solid waste.

This is an issue which will become more active with the upcoming reauthorization of the Resource Conservation and Recovery Act (EPA's authority to regulate hazardous wastes).

8. Misconduct in Research

On August 8, the PHS published the long-awaited final rule for "Dealing with and Reporting Possible Misconduct in Science" (54 Federal Register 32446). the rule, effective November 8, contains several significant changes from the Notice of Proposed Rulemaking (NPRM) published last September. The definition of misconduct was modified to include only "fabrication, falsification, plagiarism, or other practices that seriously deviate from those that are commonly accepted within the scientific community for proposing, conducting, or reporting research." The final rule also clarifies that misconduct "does not include honest error or honest differences in interpretation or judgments of data." Previously, the definition had included "deception" and "material failure to comply with federal requirements that uniquely relate to the conduct of research." These were dropped in response to public comment.

The final rule requires that grantee institutions affirm that policies and procedures are in place for dealing with allegations of misconduct. A PHS assurance form will be required annually, as will additional aggregate information on allegations, inquiries and investigations. The time frames for handling an allegation of misconduct are essentially the same as proposed in the NPRM. Institutions are to complete inquiries within 60 days to determine if allegations are valid or document the reasons for any delays. If an allegation appears to have merit, institutions must begin a formal investigation within 30 days after the inquiry, lasting no longer than 120 days. Some procedural modifications have been made to incorporate the newly established Offices of Scientific Integrity (OSI) and Scientific Integrity Review (OSIR). Institutions must notify the OSI, an NIH office, when undertaking a formal investigation; the findings must be reported to that office.

The OSIR, located in the Office of the Assistant Secretary for Health , is principally responsible for oversight of OSI activities. It also will review all final reports of investigation and make recommendations to the HHS Secretary regarding possible sanctions.

The Framework for Institutional Policies and Procedures to Deal with Misconduct in Research will be soon undergo a second printing, in part because demand for the document was greater than initially anticipated. It will also include minor modifications to account for the final rule. AAMC Memorandum #89-51 was circulated in August to the AAMC constituency to permit them to make those minor modifications in the meantime.

On a related note, the Institutes of Medicine Committee on the Responsible Conduct of Research released last February its report titled, "The Responsible Conduct of Research in the Health Sciences." The focus of the report is on how to make explicit, formal and visible those widely accepted ethical principles and standards that have traditionally governed the conduct of research. The report recommends that the NIH establish a new office, distinct from that responsible for misconduct investigations, to promote responsible research practice. It urges NIH to require by 1992 all grantee and applicant institutions to provide assurances that they have adopted policies and procedures to encourage responsible research practices and applicants to affirm their familiarity with these policies. *The report and its recommendations will be*

considered by the AAMC Ad Hoc Committee on Misconduct and Conflict of Interest in Research at its next meeting October 28.

9. NIH/ADAMHA Clarification of Policies Regarding the Payment of Salary to VA Investigators

The NIH and ADAMHA published in the August 11 edition of the NIH Guide for Grants and Contracts a clarification of the policies of those two agencies with regard to payment of salary to Veterans Administration (VA) investigators on grants, contracts, and cooperative agreements. With input from VA officials and the AAMC Division of Biomedical Research, NIH developed this policy to confirm that VA investigators may conduct research at the VA or through affiliated universities.

Previously, some investigators with joint university/VA appointments expressed to NIH and ADAMHA uncertainty regarding how much non-VA professional time could be claimed in the budget portion of the application to recover salary costs. VA appointments are expressed in terms of "eighths-time," whereby each eighth could be equated to 5 hours of a 40 hour work week. However, as this policy recognizes, most VA investigators with academic appointments have teaching and research obligations in excess of 40 hours. It had been unclear, until this policy was issued, whether part-time VA employees applying though an affiliated university could only be compensated for the balance of 40 hours less their VA commitment (VA time may not be compensated as investigators already receive a federal paycheck for that obligation).

The newly published policy recognizes that the total set of professional responsibilities may exceed 40 hours per week, but university time claimed for the purposes of salary reimbursement must be within the limits of reason. The individual's salary for his or her position with the university determines the base for calculating that salary request, the notice explains. Indirect costs are reimbursed based on the university's rate and the site of the research. Investigators applying through the VA (generally full-time VA employees) may not receive salary support as they are already receiving salary as an employee of the federal government. Indirect costs also may not be reimbursed on applications originating from the VA.

10. Postal Service Regulations on Mailability of Etiologic Agents

In an August 15 Federal Register notice (54 FR 33523), the U.S. Postal Service issued a final rule relating to the shipment of etiologic (disease-causing) agents through the mail. These new requirements, effective December 17, will affect clinical and research labs which may use the U.S. Mail to ship samples or exchange microbial cultures.

The Postal Service has been grappling with this issue for some time. It published two successive proposed rules June 24, 1988 and March 19, 1989. The original proposal would have made it illegal to send substances which must currently bear an "etiologic agent" label through the mail. It was reported to have been prompted by apprehension over the Army's growing research program on biological warfare. The June proposal, viewed as draconian by most in the research community, would have eliminated shipments of all potentially infectious organisms, regardless of virulence or how carefully they were packed. The AAMC signed onto a letter with other educational associations opposing the proposal based on the unnecessarily restrictive and costly effects it would have on the nation's research effort.

Subsequent to extensive comment and an October 1988 hearing of the House Subcommittee on Postal Personnel and Modernization, the Postal Service restructured its entire approach, working with the Centers for Disease Control and the National Institutes of Health. The new approach first appeared March 23 as a proposed rule, and has been finalized by the August 15 notice. Per the final rule, etiologic agents, clinical specimens and biological products used for medical, veterinary, laboratory certification, or research purposes may be shipped through the postal service when properly prepared for mailing. However, agents used in biological warfare will

be banned from the U.S. mail. Other new requirements for shipping etiologic agents include a 50 ml volume limitation on the amount of material that may be shipped in a single package, use of first class or priority mail for such shipments, and use of fiberboard for outer packaging. Other existing packaging requirements still apply. For shipping clinical and biological specimens, two other classes of regulated substances, the only new requirement is that they be packaged in fiberboard if the total amount of materials being shipped exceeds 50 mls.

11. Programs of the NIH Division of Research Resources

The Division of Research Resources (DRR) at the NIH is the locus of many extramural programs which provide essential infrastructure and research support to our medical schools. Last September, former NIH Director James Wyngaarden announced the merger of the DRR with the Division of Research Services (DRS), a division providing intramural support services to NIH scientists. With the merger came proposals for programmatic changes, including moving the General Clinical Research Centers (GCRC) program to the NIDDK, consolidating the minority programs and relocating the Biomedical Research Technology Support program.

An NIH task force assembled to examine organizational options associated with the merger recommended that the GCRC program stay within the DRR and largely recommended the status quo for programs under consideration. One exception to the status quo is the Minority Biomedical Research Support Program, which the Task Force recommended be moved to the NIGMS. The task force submitted its final report to the NIH Director who then formulated NIH's final proposal for the merger. The final proposal incorporated the task force's recommendations and would establish a new National Center for Research Resources (NCRR) as the hybrid of the DRR and DRS. Wyngaarden's proposal asks that the Research Resources budget, currently administered by the DRR but appropriated to the Office of the Director, be relocated to the NCRR. *The NIH proposal is awaiting the signature of HHS Secretary Louis Sullivan.*

Also of interest regarding DRR programs are recent developments related to the Biomedical Research Support Grant (BRSG) program. Although it had been eliminated from the FY 1990 President's Budget by the leadership of the NIH, it has been restored in appropriations bills at a level of $44.4 million on the House side and $55.4 million in the Senate version. The Senate figure is slightly less than last year's appropriation and compares to an Association recommended funding level of $58.5 million (the FY 1989 appropriation plus 5.6 percent for inflation).

On a related note, early this past summer former NIH Director James Wyngaarden asked BRS staff to develop an options paper on the future of this program. He has asked for consideration of an updated, revitalized definition of the program consistent with the program's original intent. Program staff presented this request to the program advisory committee which recommended a two-tiered approach to the formula mechanism. The advisory committee recommended that the formula grant be funded at a level of $100 million (almost twice current levels) and that separate formulas be applied in making awards to small, "emerging" institutions (to increase their awards three- to four-fold) and to larger, more research-intensive recipients (to double their awards). This recommendation was eventually considered by NIH Deputy Director for Extramural Research Katherine Bick who acknowledged that such funding levels were unlikely to occur. Instead, she counterproposed at the September 21 DRR Advisory Council meeting that use-restrictions be applied. Her proposal was that the less research-intensive grantee institutions be limited to using the BRSG funds for pilot projects and that larger institutions use those funds for the interim support of investigators only. This proposal was roundly rejected by the DRR Advisory Council on the grounds that such use-restrictions would undermine the flexibility that makes the program so effective at meeting very specific institutional needs. Further NIH action is uncertain at this point.

12. Research Training and the Stipend Increases

Last year, the Public Health Service (PHS) approved an increase in stipend payments to trainees and fellows receiving National Research Service Awards from $6,552 to $8,500 per year. The increase became effective beginning FY 1989, but the appropriations for this program did not increase commensurately. As a consequence, there were initially insufficient funds to sustain the number of trainees in the system from the prior year and severe cut-backs were threatened. The Medical Scientist Training Program (MSTP) of the National Institute of General Medical Sciences (NIGMS) was particularly hard hit. That institute was initially only able to pay competing MSTP awards at 20-30% of the prior year's levels. These decreases and the protests of the research community resulted in a reprogramming request by NIH. The NIH asked OMB for approval to reprogram $13.7 million to research training programs from other grant mechanisms. Although the proposal was approved, OMB was concerned about the amount of the reprogramming request. NIH subsequently revised the amount to $9.961 million, of which $2.5 million was permitted to come from research project grants that are not classified as basic research. ***The revised reprogramming package was approved by the House and the Senate Labor-HHS-Education Appropriations Subcommittees in early July. The reprogramming permitted nearly complete restoration of most training programs. NIGMS reports that MSTP awards up for competing renewals have been completely restored to the prior year's levels.***

13. Salary Cap on PHS Grants

The FY 1990 President's budget contained a proposal to cap salaries on PHS grants at $120,000. Initial research conducted by the Division indicated that a $120,000 cap on the rate at which salary is recovered on grants could prove inhibitory for certain segments of our faculty, particularly in the clinical sciences. Contacts with faculty members in various specialties have yielded varying points of view over this issue. Some individuals contacted representing basic science specialties viewed the cap as an effective means to get "greater mileage" out of limited research funding. Those representing clinical specialties expressed grave concern over the cap and worried about incentives adverse to research that it might create.

Although the House Appropriations subcommittee rejected the Administration's proposal, the Senate Appropriations Committee picked up on the cap concept and reported in the FY 1990 Labor-HHS-Education funding bill the following language with regard to the NIH salary cap issue:

> *In order to advance the Committee objective of increasing the number of research project grants, the Committee has supported the Administration request to cap extramural research salaries at $120,000 of NIH funds. This cap will save approximately $10 million and should permit another 50 research project grants to be awarded. Clearly individual researchers can earn in excess of $120,000 if their supporting institutions provide additional funds.*

The administration has requested that salaries be capped at the rate of $120,000 per year, which means that investigators claiming 50 percent effort, for example, could draw a maximum of $60,000 of the grant funds for salary.

Regardless of the effect that such a cap would have on the ability of research to recover the full costs of research, the Association believes that the overriding issue of concern for its constituents is the dangerous precedent that such a ceiling represents in terms of congressional intervention in determining scientists' salaries. In addition, such ceilings once in place become easy targets for "ratcheting down" and could become increasingly restrictive. Based on these considerations, the Association this month urged CAS members, through their key AAMC liaisons, to contact members of the House Labor-HHS-Education Appropriations Subcommittee to ask them to uphold the House position and reject the Administration's request.