



**association of american
medical colleges**

April 6, 1983

MEMORANDUM

TO: Lynn Morrison
FROM: Mary H. Littlemeyer
SUBJECT: History of CAS Brief

In 1971 when Gus Swanson joined the AAMC, he initiated a communication called the "CAS Brief" whose purpose was a call to action for CAS representatives and officers of member societies.

At its September 17-18, 1975 meeting, the CAS Administrative Board endorsed a new format and purpose for the CAS Brief, to be a quarterly communication dealing with issues and limited to two sides of one page that organizations could distribute to their members. Tom Morgan solicited views of representatives and officers of CAS constituents in a memorandum (see attached) on September 23, 1975. The response was favorable and the first issue with the revised format and content appeared for the fall of 1975. A copy of that issue and an accompanying flyer that promoted the CAS annual meeting are also attached.

Please let me know if you require additional information.

Attachments



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

September 23, 1975

TO: Representatives and Officers
of Constituent Societies of the CAS

FROM: Thomas E. Morgan, M.D., Director
Division of Biomedical Research
Department of Academic Affairs

At the suggestion of the Administrative Board of the Council of Academic Societies we are exploring a new purpose for the *CAS Brief*. In the past the *Brief* has served as a call to action for the CAS Representatives and Officers of the member societies. Often this call has been accompanied by a position paper which served to focus attention on acute problems facing academic medicine in the public sector. Experience has shown that this call to action was sometimes unsuccessful because insufficient prior information exchange had occurred to acquaint those concerned with the nature of the problem and the individual members of each society were not reached.

We are, therefore, undertaking to produce a new type of brief which we hope will be sent by you to your members. The first of these is enclosed. You will note that it covers both sides of a single page and that it addresses one topic at length and several additional topics in somewhat lesser detail. We intend by this means to summarize for your members major public policy issues which face the American biomedical research and education community and which in our judgment may become urgent problems in the future. It is not our purpose in this new *CAS Brief* to provide the detailed coverage of news items provided through the Association's Weekly Activities Reports which are available through your membership.

The *CAS Brief* will be sent four times a year. We anticipate mailings in late January, early April, late June and late September. Specific dates will be established and you will be informed so that you may coordinate receipt of the *Brief* with mailings to your membership. Intermittently, and as needed, "CAS Alerts" will be sent to you. These will be targeted towards specific problems or issues requiring some form of response.

We would like to have your candid reaction to this plan, and particularly to this first issue of the *CAS Brief*. A letter or telephone call to me or Gus Swanson would be very much appreciated. Alternatively, we would be glad to hear your opinion of this effort at the time of the CAS Annual Meeting. Our intention is to increase useful communication with the members of the constituent societies whom we represent. We hope sincerely that the Secretary of your organization will reproduce by photocopy these quarterly *Briefs* and send them to your members. If there is any way that we can facilitate this distribution we would be very happy to consider your suggestions.

Please let us hear from you. We need your feedback and ideas.

Enclosure

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 FALL, 1975 VOL. 1, NO. 1

This first issue of CAS Briefs was prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society. Four issues will be mailed each year. The purposes of the CAS Briefs are stated below.

CAS BRIEF. Maintaining the integrity, viability, and quality of biomedical research and education in this country are important concerns of member organizations of the Council of Academic Societies and their constituents. Today more than ever before these concerns are subject to changing public policy. Although keeping informed on the details of each and every proposed or actual policy modification is extremely difficult, the major implications and their potential impact on basic principles related to the conduct of biomedical research and education can periodically be summarized. Through this quarterly CAS Brief such summaries will be provided. Further detail can be obtained by calling or writing the Department of Academic Affairs. From time to time CAS Alerts will be sent to the officers and representatives of member societies. Through these the need for immediate responses or action can be satisfied.

HEALTH MANPOWER BILL. Renewal of the Comprehensive Health Manpower Training Act which expired June 30, 1974 is still a subject of debate in the 94th Congress. In July, 1975 the House passed a bill (HR 5546). The Senate Health Subcommittee is planning to hold hearings during the next 2 to 3 months. The debate over the renewal of this Act is around 3 major public policy concerns:

Aggregate supply of physicians. Even though the number of entering students has increased from 8,759 in 1965 to nearly 15,000 in 1975 schools may be required to increase their class size in order to qualify for basic support through capitation.

Specialty Distribution. A provision in HR 5546 which would have provided the Coordinating Council on Medical Education an opportunity to designate the number of individuals to be trained annually in each specialty was removed by amendment. The only support for primary care training is for family practice residencies and undergraduate programs.

Geographic Distribution. HR 5546 provides that medical schools not choosing to increase class size must provide education in remote sites to a specified proportion of their students. The Senate Subcommittee is still considering a mandatory requirement for federal service as a condition for admission to medical school. Increased support for the voluntary National Health Service Corps is contained in HR 5546 and likely to be in a Senate bill.

Of great concern to the AAMC and the CAS is the propensity for both Houses of Congress to dictate numerous requirements for the schools to qualify for essential capitation support. The freedom and flexibility of the academic medical centers and their capability to fulfill their responsibilities will be seriously curtailed if this movement persists and grows.

BIOMEDICAL RESEARCH FUNDING. The President's Biomedical Research Panel was created by Congress in mid-1974 and appointed February 1, 1975. At their spring meetings the Council of Academic Societies and the Council of Deans formulated opinions and presented testimony to members of the Panel. They emphasized their concern for the instability of research funding, the need for support of research training programs and basic biomedical and behavioral research, and the need for increased participation of the research community in the planning of future biomedical and behavioral research initiatives. Responding in part to this dialog, the President's Panel set up a number of study groups of scientists whose responsibility is to examine the state of the art of 12 clusters of research endeavor and to advise the Panel what steps should be taken to conduct research more effectively in each area.

The Association took a leadership role with the staff of the President's Panel to assess the stability of research funding and the trends occurring in the pattern of federal involvement in the research effort. As a result, a study of the impact of federal research funding on the academic medical center has now been undertaken by a consortium of the AAMC, the American Council on Education, and the Rand Corporation under contract with the Panel. Efforts to date have been the construction of a data base which will depict the dimensions and trends in funding of academic medical centers in the past decade. Construction of the computerized data base for addressing questions about the impact of research funding on academic medical centers is now near completion. It will be completed by January, 1976.

CONFIDENTIALITY OF RESEARCH GRANT PROTOCOLS. The peer review system employed by NIH for awarding grants and contracts is widely recognized as outstanding. This award process has been conducted under rules in which the applications are submitted and reviewed in confidence. This system is now buffeted by a series of post-Watergate waves seeking to insure openness in governmental operation. The Freedom of Information Act (FOIA) of 1967 has been employed by public interest groups seeking to safeguard the rights of children to support their requests for access to grant applications. In a landmark court decision, Judge Gesell agreed that research applications should be made public.

As a result of the Gesell decision, more than 700 requests for applications have now been received by NIH. However, the issue is not simply one of revealing funded grant applications to those who request them but also involves the peer review process, the intellectual property rights of scientists, the protection of human subjects of research, the protection of the public from premature exploitation and the patent rights of individuals. The struggle to resolve these conflicting ideals is far from concluded. Public interest groups continue to seek not only funded grants but all applications and access to study section proceedings as well. In Congress, supporters of complete access threaten additional legislation to compel disclosure of pink sheets and to open all grant review meetings. The AAMC has drafted a position paper dealing with this problem which will be published in Clinical Research in late 1975. Copies of this paper are also available on request.

AAMC ANNUAL MEETING

NOVEMBER 2-7, 1975

COUNCIL OF ACADEMIC SOCIETIES ANNUAL MEETING

Monday, November 3
9:00 a.m. - 5:00 p.m.
Washington Hilton Hotel
Washington, D.C.

Your attention is called to the longer time set aside for the meeting this year and to the different format. In the past CAS members have been addressed by speakers on a variety of topics. This year, as part of the increased emphasis on participation of member societies in the program, we are asking you to speak out on topics that concern you. To allow ample time for discussion by CAS representatives and officers of major issues of interest, a full day's session, Monday, November 3, 9:00 a.m. - 5:00 p.m., has been allocated. Along with the regular business items and election of officers, topics that will be open for discussion will include such issues as:

Health Manpower
Biomedical Research Impact Study
Biomedical Research Training
Coordinating Council on Medical Education (CCME) and
Liaison Committee on Medical Education (LCME)
Liaison Committee on Graduate Medical Education (LCGME)
Liaison Committee on Continuing Medical Education (LCCME)
Commission for the Protection of Human Subjects
Confidentiality of Research Grant Protocols
Medical College Admissions Assessment Program (MCAAP)
Faculty Development
Faculty Roster and Institutional Profile System Reports
National Intern and Resident Matching Plan (NIRMP)
Audiovisuals On-Line (AVLINE)

The CAS special half-day program, scheduled for Wednesday, November 5, 2:00 p.m. - 5:00 p.m., will be co-sponsored by the Council of Deans (COD) and the Council of Teaching Hospitals (COTH). The feature of this session will be "Maximum Disclosure: Individual Rights and Institutional Needs."

Mark your calendar for these events:

Sunday Nov. 2	Monday Nov. 3	Tuesday Nov. 4	Wednesday Nov. 5	Thursday Nov. 6
	CAS Annual Meeting 9:00 am - 5:00 pm	AAMC Assembly 1:30 - 4 pm	CAS/COD/COTH Program - "Maximum Disclosure" 2-5 pm	
	A A M C	A N N U A L	M E E T I N G	

The agenda for the CAS Annual Meeting will be forthcoming.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 WINTER, 1976 VOL. 1, NO. 2

HEALTH BUDGET. On January 28-29 Congress overrode President Ford's December 19 veto of the Labor-HEW Appropriations Bill for fiscal year 1976 by large bipartisan votes. This event signalled the beginning of the election year in Congress and will certainly make more difficult the Administration's desire to trim NIH spending between now and September (FY 76). Although the battle is won, the war is far from over. OMB and the President will likely try to cut as much as 200 million dollars out of the current NIH budget with deferrals and recissions which must be acted on individually by Congress. However, deferrals should be more difficult now that Congress has acted decisively. Several sensitive areas remain to be watched:

Fellowship and training grants. Fellowship and training grant applications were solicited and received by NIH until early January. New training grant authority (called National Research Service Awards) should become law soon. A supplemental appropriation bill must follow, and this, too, runs the risk of veto. Thus, OMB may be tempted to defer all training starts and renewals past July 1. Meanwhile NIH waits expectantly, needing clearer signals for action.

Research grants. Grants assigned to "have-not" institutes (all except the Cancer Institute) continue to be in trouble in spite of the override. Grants approved at November Councils may not be funded if OMB pushes deferrals. In the latter event, no new starts will be made until after July 1. The next two months will reveal Administration strategy here, and Congressional pressure may be needed.

President Ford's 1977 Budget message has also been received. This continues NIH spending at about the fiscal 1975 level. Due to the effect of inflation, however, "1975 Spending" means spending 12% less in 1977. Nevertheless, the 500 million dollar cut for NIH which Washington observers had feared did not materialize. This, coupled with Congress's action, makes the biomedical research outlook brighter but certainly not rosy.

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT. This legislation (P.L. 93-641) passed by Congress in 1974, is now in the process of implementation. The intent of the law is to provide local review and supervision of the allocation of federal funds to health facilities and resources. Through local Health Systems Agencies (HSA) within the states and State Health Planning Development Agencies at the statewide level, approval will be required to expand facilities and services, modify existing programs, or institute new programs.

The degree to which the local and state agencies will be empowered to review and approve the allocation and use of resources generally considered to be of national scope (e.g. research grants and contracts and graduate medical education programs) remains an open question. Involvement of academic faculties at both local and state levels is important. It is suggested that faculties arrange briefings within their institutions in order to become familiar with the status of development of the HSA and State Agency in their region. For more detailed information contact Tom Morgan at AAMC.

BIOMEDICAL RESEARCH FUNDING. Results of the study of the impact of biomedical research funding on the nation's academic medical centers have just been presented to the President's Biomedical Research Panel (See CAS Brief Vol. 1, No. 1, Fall 1975). The study showed that the growth of biomedical research funds from 1964 to 1974 was 78% in current dollars but only 6% in constant dollars (taking inflation into account). At the same time total operating budgets of academic medical centers increased 82% in constant dollars due to larger amounts of state funds (primarily for teaching) and of professional fees and other clinical income for patient care.

As a result of the heavier involvement of faculty of the medical centers in educational and clinical activities, federal research revenues declined from 36% to 21% of total operating budget over the 10-year period. Other indicators of this changed effort at academic centers was the 50% increase in students and the 105% increase in faculty.

Academic medical centers with the heaviest research emphasis showed an overall dollar increase in research funding but a decline in research funding as a proportion of the total budget. Curriculum changes could not be related to biomedical research funding. Family medicine programs were just as likely to be started at academic medical centers having heavy research emphasis as at those less involved in research.

EEOC EYES PROFESSIONS. A proposed revision of EEOC guidelines would have a profound impact on the admissions process, education, certification, and licensure procedures for the professions. The guidelines previously have been applied only to personnel selection and hiring practices in industry. The obvious objective is to facilitate access to employment in the professions for groups currently underrepresented. "Discrimination" (adverse impact) in selection procedures is defined as the experience of any group not achieving at least 80% of the success rate of the most successful group. Where adverse impact is discovered, evidence of satisfactory validity must be supplied which demonstrates that success on the job is directly related to selection measures and criteria and to the same extent that the latter are weighted in selection decisions. One assumption seems to be that the possibilities for measuring competencies of an assembly line worker are comparable to those for measuring the performance of physicians, teachers, and researchers. This example of federal regulatory agencies ever extending their authority is a sign of the times.

AAMC is cooperating with the American Board of Medical Specialties, the Council of Medical Specialty Societies, the American Hospital Association, the Educational Council for Foreign Medical Graduates, and the Federation of Associations of Health Regulatory Boards in attempting to challenge the extension of EEOC's jurisdiction to the professions.

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 6, 1976

MEMORANDUM

TO: OFFICERS AND REPRESENTATIVES OF MEMBER SOCIETIES
COUNCIL OF ACADEMIC SOCIETIES

FROM: August G. Swanson, M.D., Director of Academic Affairs

SUBJECT: Cancellation of Spring Meeting

At the Administrative Board Meeting of the Council of Academic Societies in January, the Board reviewed the plans for having a Spring Meeting in Philadelphia on March 16. It was decided to cancel the March 16 meeting because of the heavy schedule of professional meetings, and the fact that a one-day meeting in Philadelphia could not fulfill the desires of the Board to improve the interactions of member societies with federal agencies.

The Board decided to explore the development of an alternative meeting in Washington, D.C. which would allow representatives to the CAS to meet with persons in government concerned with academic medicine. This proposed legislative workshop would be specifically directed towards those individuals in the member societies who will have significant and long-term involvement with the societies' legislative and governmental concerns. Further information about these plans will be communicated at a later date; however, we would appreciate your reaction to this proposal, using the attached form.

Attachment

AGS/ms

COUNCIL OF ACADEMIC SOCIETIES
PROPOSED LEGISLATIVE WORKSHOP

(Name)

(Society)

I agree _____ disagree _____ with the proposal for
a CAS Legislative Workshop to be held sometime in late Spring, and
I would _____ would not _____ be interested in attending.

Please return this form as soon as possible to:

August G. Swanson, M.D.
Director of Academic Affairs
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

May 14, 1976

TO: Representatives and Officers of Constituent Societies of the CAS

FROM: AAMC Department of Academic Affairs, August G. Swanson, M.D., Director,
and Thomas E. Morgan, M.D., Deputy Director

In September 1975, when we introduced the communication series which we call the CAS Brief, we explained its purpose and tentatively proposed a quarterly production schedule. Pending developments in the current health manpower legislation, we have delayed the Spring issue until now. Two copies are enclosed.

As we indicated originally, we hope that in this two-page newsletter major public policy issues are adequately summarized and that you will feel, as we do, justified in reproducing it for distribution to your members.

In this way, and perhaps with your own additions, your members may be afforded an opportunity not otherwise available to them to make their views known relative to these important national issues.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 SPRING, 1976 VOL. 1, NO. 3

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.

HEALTH MANPOWER BILL. The Health Professions Educational Assistance Act of 1976 (S 3239) has been reported out of committee and will go to the full Senate in the near future. The bill extends present health educational authorities through fiscal year 1977. The new provisions of this act will be in effect through FYs 78, 79, and 80.

Capitation support is authorized at levels of \$1,800, \$1,900, and \$2,000 per enrolled student in each fiscal year. This provides for a \$100 per year/per student increase through the life of the act. The bill emphasizes modifying physician distribution in the following ways:

Geographic Distribution. Authorization sufficient to provide Public Health Service scholarships to a number of medical students equivalent to 25%, 30%, and 35% of the entering classes in academic years 77, 78, and 79 are intended to expand the National Health Service Corps. This could provide 3,800 to 5,500 physicians annually to the Corps by 1981 to 1985. The bill requires that if the established quotas for PHS scholarship acceptance are not met across the Nation, each school must meet the quota from among its enrolled students in order to qualify for capitation. The AAMC is attempting to introduce technical modifications to ensure that earlier provisions which required students to pledge acceptance of a Public Health Service scholarship prior to admission are removed.

Specialty Distribution. A second major focus is aimed at primary care residency training programs. Special project support for programs in family medicine, general internal medicine, and general pediatrics is authorized. The bill also requires that medical school affiliated teaching hospitals have 42% of their filled residencies in primary care specialties (including a maximum of 7% in obstetrics-gynecology) in the academic year 78, increasing to 47% and 57% in the subsequent two academic years. If these percentages are met in the national aggregate, then individual academic medical centers need not specifically meet the quota level. However, if the national averages are not met, then each center must meet the quota percentage in order to receive capitation.

A national and 10 regional commissions are established to oversee graduate medical education. These commissions are empowered to designate residency positions which may or may not be filled. It is expected that the bill will require the commissions to recognize the accreditation authority of the Liaison Committee on Graduate Medical Education.

Opportunities for foreign medical graduate migration are significantly reduced.

The bill runs to 248 pages. The provisions discussed above are those of major concern. In its present form the bill is acceptable and is supported by the CAS/AAMC.

HEALTH CARE SOLUTIONS SOUGHT. DHEW Assistant Secretary for Health, Dr. Ted Cooper, recently challenged the academic community to work with him toward solving what he believes to be the most pressing problems facing the Nation's health care system: (1) developing means to control the rising demand for health services, and (2) developing strategies to reduce health care costs.

At a subsequent meeting between AAMC staff and Dr. Cooper's staff, it was agreed that in the public interest we need to attack these problems. A meeting of the Administrative Boards and Dr. Cooper is scheduled for June 23. A small working group from the AAMC's Councils will meet in advance on June 10 to discuss the issues surrounding these complex problems. CAS constituents are urged to communicate their ideas to Gus Swanson or Tom Morgan.

PRESIDENT'S BIOMEDICAL RESEARCH PANEL ISSUES FINAL REPORT. The long-awaited report of the President's Biomedical Research Panel was released on April 30, 1976. The 7-member panel deliberated for 15 months, received testimony from numerous public and private witnesses, and commissioned several extensive studies on the status of biomedical research, the management of the NIH and ADAMHA, and the impact of federal biomedical research funding on academic institutions.

The Panel found that NIH and ADAMHA are carrying out their programs of fundamental research in a responsible way and that no "undue delay exists in making research findings available to the nation's health care practitioners." Any lag in the translation of results from the laboratory to the care of patients was felt to be beyond the control of the research community. The Panel recommended that NIH/ADAMHA have limited activity in the areas of health care research and delivery. Science advice to the President and the Congress should be strengthened by statutorily reconstituting the President's Cancer Panel as the President's Biomedical Research Panel to advise on all NIH programs. Changes were also recommended in the structures of the advisory board and councils to the NIH and institute directors. The Panel found that NIH is doing a good job and that no major change in the categorical organization is needed.

Strong support was expressed by the Panel for the investigator-initiated, peer reviewed grant as the predominant vehicle for the support of research. Considerable emphasis was put on strengthening the peer review process and particularly for amending the "sunshine laws" so as to provide statutory assurance that the initial review for scientific and technical merit remains totally confidential.

Stability of funding for institutions which perform the research supported by NIH and ADAMHA constituted a major focus in the report. The Panel found that federal support for research has strengthened research capabilities of universities but that changes in federal policies and practices have begun to impose difficulties which could prove detrimental to the research capabilities of the institutions. Academic medical centers were reported to have been very responsive to service and health manpower needs of society. The federal government was urged to adopt a policy of full cost reimbursement for federally sponsored research. Finally, a number of recommendations were made for strengthening the intramural programs of NIH and 4 areas of future emphasis were singled out. The full Panel Report and 4 appendices will be available from the USGPO (DHEW Publication No. (OS)76-500).

The Panel Report reaffirms many positions long held by AAMC, views not shared by Senator Edward Kennedy (D-Mass.) who in a recent speech at Tufts University charged that the real question is whether the nation is using medical research effectively and for the right purposes. The results of the 15-month Panel study indicate that the nation is getting its money's worth; however, Senator Kennedy will use the Panel Report to begin NIH oversight hearings. Panel Chairman Franklin Murphy and other members are expected to be subjected to intense questioning by members of the Senate Subcommittee with respect to results of their study.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 466-5100

• 1 DUPONT CIRCLE NW
FALL, 1976

• WASHINGTON DC
VOL. 2, NO. 1

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.

RECENT CONGRESSIONAL ACTION. As the 94th Congress drew to a close a large number of bills, some of them months in preparation, were hastily passed. The fate of several bills and a look ahead at the work of the next legislative session will interest the biomedical community.

Health Manpower Bill. H.R. 5546, the Health Professions Educational Assistance Act of 1976, was substantially modified in the House-Senate Conference Committee and signed by the President on October 12, 1976. The requirements medical schools must meet in order to receive capitation are: On July 15, 1977, 35% of filled first-year graduate (GME-1) positions in direct and affiliated hospitals must, in the national aggregate, be in the primary care specialties of family practice, internal medicine, and pediatrics (ob-gyn was excluded in Conference); on July 15, 1978, 40% must be in primary care; and on July 15, 1979, 50%. If these national percentages for primary care positions are not met, then only schools meeting or exceeding these percentages in their own direct and affiliated hospitals will receive capitation. The Act requires that in counting GME-1 positions in primary care, the Secretary shall discount from the total, the number who enter other training programs in their second graduate year.

A provision for U.S. citizens studying medicine abroad, which was not in either the House or Senate bills, was generated in the Conference. This provision requires that to receive capitation, schools must admit a number of students (the number to be apportioned equitably among all schools) who have successfully completed two years in a foreign school, have passed NBME Part I, and have applied to the Secretary for apportionment to a school. Specific individuals will not be assigned to schools, but schools may not deny admission on academic grounds to students who have passed Part I, NBME. This highly controversial provision encroaches on the right of faculties to select students. It is anticipated that because the provision was inserted into the Act without prior discussion or public hearings, legislative review and modification may be possible in the next Congress.

Among the other provisions, the Act authorizes special project grant support for the development of graduate programs in the primary care specialties of family practice, internal medicine, and pediatrics. It also extends the National Health Service Corps and increases the authorization levels for the Corps.

After three years of debate through two sessions of Congress, the final bill, with the exception of the U.S. foreign medical student provision, is reasonable and provides for federal support for medical education in a satisfactory manner.

1977 Labor-HEW Appropriations Bill. This \$56.5 billion bill, the first appropriations bill in recent memory to be completed before the start of the fiscal year, was vetoed by President Ford at the last possible moment. Congress responded in one day with a resounding override vote. The NIH budget is thus assured with, as usual, a comfortable increase for the Cancer Institute, a lesser one for the Heart, Lung, and Blood Institute, and allowances which barely keep up with inflation for most of the rest of NIH. Training grants suffered severely in FY 1976 due to late renewal of their authorizing legislation and will continue down in 1977. For example, the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), which funds most clinical training grants, received a training appropriation of about \$9 million (down from \$15 million in fiscal 1975) but because of specially earmarked new programs such as the Arthritis and Diabetes Advisory Boards, NIAMDD may have less than \$7 million available for training.

Other Bills. The statutory Diabetes and Arthritis Boards were created at the end of the session. Authority for emergency medical services was renewed with much more emphasis on physician and allied manpower training than in the previous law. The Clinical Laboratories bill failed despite much work and agreement as to a need for its antifraud provisions. Clinical research laboratories would have been affected by this bill and by regulations still proposed by HEW.

WHAT'S AHEAD IN 1977. Next year will be a banner year in Congress for biomedical research legislation. The Cancer Act, the Cardiovascular, Lung, and Blood authority, the Research Training Act, and HEW Appropriations must be renewed in 1977. Also, the Senate Health Subcommittee has served notice it intends to conduct a thorough review of the mission of NIH with special emphasis on ways to increase applied research, clinical trials, and the transfer of research ideas to patient care. These "technology transfer" functions will likely be the main theme for the coming year if recent hearings are indicators of the trend. The Congress will undoubtedly attempt again to increase the scientific expertise of the Food and Drug Administration. Clearly, the biomedical research community must labor skillfully and persistently to justify stable funding, basic research, and research training in the coming year. Common goals must be emphasized and partisan concerns must be played down in support of the basic policies of importance to the total endeavor.

Although, as noted above, the Clinical Laboratory Improvement Act of 1976 failed to pass, the Administration held hearings August 26, 1976 to discuss possible regulations under the Clinical Laboratory Act of 1967. The Administration believes that the best way to assure that the output of laboratories meets high standards is to require that laboratory technicians be well trained and, usually, graduates of clinical laboratory programs. Laboratories must be headed by board-certified directors. These requirements will apply to all clinical laboratories including those which are performing clinical research. Clearly, such requirements would impede clinical research. CAS/AAMC are working to modify these rules.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 WINTER, 1977 VOL. 2, NO. 2

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.

BIOMEDICAL RESEARCH - UPDATE 1977. The 95th Congress faces a half-dozen expiring health-related legislative authorities. At least three major acts directly affecting biomedical research require renewal this Spring: National Cancer Act; National Heart, Lung, Blood, and Blood Vessel Act; and National Research Service Awards Act (research training).

Anticipating the need for increased interaction between the Congress and the academic community, the CAS initiated a network of public affairs representatives in November and held a workshop with these representatives and Congressional staffers in December. In addition, on January 19, the CAS Administrative Board met with Mr. Stan Jones and Dr. David Blumenthal, of the Senate Health Subcommittee staff, for a discussion of the academic concerns relating to biomedical research and technology transfer.

Indications are that the Carter administration would prefer a simple one-year extension of the expiring laws to allow time for formulation of new policies. Such extensions would be useful to Congress also since the overview of biomedical research which began last June did not progress as rapidly as expected. A year's delay would provide time for more extensive hearings and, hopefully, for revisions of the counterproductive provisions of present authorities.

Two factors are working against one-year extensions, however. First, supporters of the cancer and heart-lung-blood programs favor three-year renewals. Second, many in the research community are now quite comfortable with the present funding arrangements and fear that any changes may be for the worst. It is clear that Congress realizes that the pressure for categorical disease programs ("disease-of-the-month authorities") would be increased by the longer extensions of existing categorical disease programs. Congress has also become aware that categorical disease programs tend to push up health care costs and, because the NIH budget is not expansible, actually to decrease the funds available for support of biomedical research. The proposed NIH biomedical research budget will increase only about 2% to \$2.505 billion which, in view of inflation, amounts to an actual decrease in most Institutes. In addition, OMB continues to press for elimination of general research support and institutional research training grants. For all these reasons, the next few months will see much activity by the Academic Societies, AAMC, and Congress.

Contact Tom Morgan, M.D., at AAMC, for more detail.

HOUSESTAFF AND THE NATIONAL LABOR RELATIONS ACT. Collective bargaining for graduate medical student unions under the provisions of the National Labor Relations Act (NLRA) has been sought by the Physicians National Housestaff Association (PNHA) since public hospital employees were included in the Act in 1974. The PNHA argument is that residents are at once both employees and students and that collective bargaining would be imposed only upon conditions of employment and not on educational issues.

To date, in 5 cases wherein housestaff unions have sought to bargain under the provisions of the NLRA, the National Labor Relations Board (NLRB) has dismissed the house officers' petitions in a decision of fact, finding "... that interns, residents and clinical fellows are primarily students ... not employees within the meaning of the Act." On January 19, 1977 Congressman Thompson (D-NJ) re-introduced a bill (first introduced last fall) that would include house officers under the provisions of the NLRA.

AAMC Stand. The AAMC filed an *amicus brief* in the cases before the NLRB in 1975 holding that the student-teacher relationship necessary to conduct effective graduate medical education could not be achieved through the adversarial relationship of employee-employer imposed by the NLRA. The AAMC position is that the resident is a student whose relationship with the hospital should be based on an educational rather than an industrial model and that adoption of the latter relationship would imperil the educational mission from several points of view:

- The fundamental relationship between the interns and residents and the program director and the teaching staff would be changed from one of student-teacher to employee-employer.
- The program director would no longer be able to shape each individual's training to suit the individual's educational needs but would have to deal with "employees" on a collective basis.
- Hospitals would be expected to bargain about issues over which they have no control.
- The educational emphasis of graduate medical education would be replaced by a new emphasis upon wages, hours, and terms and conditions of employment.
- As the programs at affected hospitals changed from ones with emphasis upon education to ones with emphasis upon the material elements of the employer-employee relationship, graduate medical education programs would face loss of accreditation.
- The NLRB would necessarily become the final arbiter of the content of graduate medical education by virtue of defining the scope of collective bargaining in affected programs.

House officers who are proponents of the Thompson bill are quite active at the national and local levels. Program directors are urged to discuss with their residents the claims by many that collective bargaining under the NLRA will improve patient care and graduate medical education. It should be emphasized that more stringent application of accreditation standards by the Liaison Committee on Graduate Medical Education (LCGME) can be used to upgrade or weed-out substandard educational programs.

Write August G. Swanson, M.D., at AAMC, for further details.

AAMC ANNUAL MEETING - November 5-10 - WASHINGTON HILTON HOTEL
THEME: Graduate Medical Education

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 SPRING, 1977 VOL. 2, NO. 3

HEALTH MANPOWER ACT. The Health Professions Educational Assistance Act of 1976 (P.L. 49-484) was signed by President Ford on October 12, 1976. Implementing regulations have developed slowly, in part because of the complexity of the law and in part because of the cumbersomeness of the DHEW regulation review procedures. In addition to the usual assurances of first-year enrollment levels and institutional nonfederal expenditures, capitation funding hinges on requirements in the two areas described as follows:

Primary care residency positions. Effective July 15, 1977, 35% of all filled residency positions must be in the primary care specialities of internal medicine, pediatrics, and family medicine in those programs operated in facilities that are either owned by or affiliated with medical schools. If a position was filled in 1976 by a resident who is no longer in a primary care residency, that position will be discounted from the total primary care count.

Major concerns surround the definition of an affiliated program and the nonprimary care positions. The Department's proposals for these will be published in a Notice of Intent of Proposed Rule Making to be released in May.

If the 35% proportion is not met in the July 1977 count, all schools seeking capitation will have to have a 40% proportion in primary care in 1978 and a 50% proportion in 1979. At present, available data from AAMC and from the National Intern and Residency Matching Plan (NIRMP) indicate that the 35% national level will be met in 1977.

U.S. students in foreign medical schools. In the academic year 1978, medical schools will be required to reserve a number of places sufficient for the transfer into the second-, third-, or fourth-year classes of U.S. citizens who were enrolled in foreign schools prior to October 12, 1976. These transferring students must have successfully completed two years of study and must have passed Part I of the National Board of Medical Examiners (NBME).

Implementation of this provision is extremely complex. The problems of identifying eligible students, apportioning positions among the schools on the basis of enrollment, and facilitating the application to schools by students are complicated by the fact that some schools may not participate at all in the capitation, and others may request and receive waivers from this provision. At present, the Bureau of Health Manpower hopes to have applications for students to send to the Secretary in the mails by June 1, but the Office of Management and Budget must clear these forms.

Upon receiving the application forms, students will find they must get their foreign schools to send a transcript and an affidavit stating that they have successfully completed two years of study. Obtaining these documents from many foreign schools may be difficult. At present, the Bureau of Health Manpower is considering developing a matching program. Such a program would assist both the students in their search for a place and the schools in demonstrating that they have made a good-faith effort to fill their reserved positions.

Special projects. The Act authorizes support of residency programs in general internal medicine and general pediatrics through grants or contracts. Application materials for these projects were sent to every medical school dean's office on April 15. The deadline for receipt of completed applications by HRA is May 30.

Foreign medical graduates. The law returns the Exchange Visitor Program to its original intent--that foreign physicians be educated in U.S. institutions in order that they may serve their own countries' needs. Future graduates of medical schools not accredited by the Liaison Committee on Medical Education who come to the U.S. to participate in programs involving patient care must have their programs arranged between governmental agencies or institutions in their countries of origin and U.S. medical schools and their hospitals. The physician must pass Parts I and II of the National Board (or its equivalent). The NBME will give this exam on September 7-8, 1977, in 20 locations throughout the world.

It is expected that by 1978 the number of foreign medical graduates entering U.S. programs in graduate medical education will be reduced to a trickle. Meanwhile, the number of U.S. graduates is rising. Approximately 13,800 will graduate this year.

FY 1978 APPROPRIATIONS. Federal appropriations for FY 78 are now being established. The ceiling set by Congressional Budget committees will probably be about \$8 billion for all health funds other than Medicare-Medicaid. This is \$1.1 billion below the recommendations of the Coalition for Health Funding (CHF). This constraint will seriously jeopardize attaining the CHF recommendations for NIH, ADAMHA, and the Health Resources Administration. The comparative dollar figures are as indicated in the following table:

	<u>Administration Budget Request</u>	<u>Coalition for Health Funding Budget Recommendations</u>
NIH	\$2.576 billion	\$3.070 billion
ADAMHA	.947 billion	1.101 billion
HRA	.588 billion	1.250 billion

The significant increase in HRA appropriations is needed to implement the provisions of P.L. 94-484.

Adequate funding for research and education is increasingly difficult to achieve in a climate in which the emphasis is on the containment of health costs. Members of the academic community must explain to their Congressmen that the nation's efforts in research and education are long-term investments. Short-term strategies to contain expenditures on health services must not cripple programs in research and education which, in the future, can significantly improve health status.

H.R. 2222. This bill, which would direct the NLRB to define housestaff as employees, is still in the House Subcommittee on Labor-Management Relations. It is important that the views of faculty and housestaff who oppose this bill be made known to Frank Thompson, Chairman of the House Subcommittee on Labor-Management Relations, and Carl D. Perkins, Chairman of the House Committee on Education and Labor.

The CAS Brief is prepared by the staff of the AAMC's Council of Academic Societies and is distributed through the auspices of your member society.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 SUMMER, 1977 VOL. 2, NO. 4

AAMC MEETS WITH DHEW SECRETARY CALIFANO. On June 22, the AAMC Executive Committee met with DHEW Secretary Califano and his staff. The friendly 1½-hour discussion ranged over such topics as the structure and function of academic medical centers, health manpower, biomedical research, burdensome HEW regulations and requirements, and medical education. Mr. Califano appeared eager to increase enrollment and retention of minority and women students, but his preoccupation was clearly with containment of health care costs. The special problems of teaching hospitals were made clear to Mr. Califano, but no concessions were obtained. In discussing biomedical research, Mr. Califano revealed that the President is not convinced of the value of basic research and has doubts as to what degree it should be supported by the federal government.

CONGRESS MOVES AHEAD ON BILLS TO LIMIT RESEARCH. Two bills which will, for the first time, limit research activities either directly or indirectly are moving ahead in Congress. The overall goals of the bills are laudable, but, in each case, real restraints on free inquiry are being imposed:

Recombinant DNA research. Legislation is needed to make the NIH guidelines for recombinant DNA research applicable to industry and nonfederal researchers. The House and Senate bills differ widely in many important ways, but the House version seems eminently more reasonable--it vests regulatory power in the DHEW Secretary, who will be assisted by an advisory committee. The Senate would create a regulatory commission from which those knowledgeable in recombinant DNA would be excluded. Various approaches are taken to local preemption of federal regulation, and there are many other problems, including disclosure of research information and penalties for noncompliance.

Clinical Laboratories Improvement Act. As previously reported, the AAMC fears that this Act will increase hospital costs further by setting mandatory personnel requirements. It will also inhibit the transfer of research-proven knowledge to patient care by requiring licensing and personnel restrictions in clinical research laboratories which also perform tests used for patient care. Whenever laboratory tests involve patients, the quality of these tests should certainly be assured; however, the AAMC believes that the quality of the tests performed by clinical laboratories should be safeguarded by the DHEW Secretary, who should have discretion to adopt alternate standards appropriate to the research conducted in the laboratories.

NIH/ADAMHA APPROPRIATIONS UPDATE. The Labor-HEW budget for FY 78 heads toward House-Senate conference the week of July 11, having apparently cleared the busing hurdle but still being impeded by abortion amendments. The 78 Carter budget for NIH/ADAMHA is \$3.52 billion, only \$29.5 million (1%) above 77. The House added an average of 7.2% to the 77 budget, but the Senate figure was 12% above 77. President Carter has agreed with House leaders not to veto the bill if the total Labor-HEW increase is limited to the House levels. Whether this agreement will continue is clouded by two votes of the Senate in late June sustaining full Senate increases for NIH and other parts of the budget.

GRADUATE MEDICAL EDUCATION TASK FORCE. Post-MD education of physicians is now predominantly provided within the environs of academic medical centers. The AAMC therefore has decided to exert a major effort to bring into focus the problems and issues facing graduate medical education. To accomplish this, a Task Force on Graduate Medical Education has been appointed under the Chairmanship of Dr. Jack Myers of the University of Pittsburgh.

It is intended that the task force particularly tackle eight major issues:

- The availability of graduate education positions for U.S. graduates;
- The impact of new restrictions on FMGs on the quality of graduate programs;
- The reasons for the current debate regarding the employment versus student status of residents;
- The role of institutional administrators and faculty in providing high-quality graduate medical education;
- The governance and control of graduate medical education at the national level;
- Needed changes in the review and approval process for accrediting graduate medical education programs;
- The role of graduate medical education in modifying specialty distribution; and
- Future financing policies for graduate medical education.

The task force will seek input from certifying boards, residency review committees, specialty societies, teaching hospitals, medical schools, and other agencies involved in graduate medical education.

For a synopsis of the issues facing the task force, contact August G. Swanson, M.D., Director, AAMC Department of Academic Affairs.

CAS INTERIM MEETING HELD. Forty-seven societies were represented at the CAS Interim Meeting in Washington, D.C., on June 22. Current policy issues in biomedical research, medical education, and health care involved the participants in a vigorous exchange of information.

AAMC/CAS FUTURE MEETINGS. The AAMC/CAS Annual Meeting dates are November 6-10 at the Washington Hilton, Washington, D.C. The CAS Annual Business Meeting is Monday afternoon, November 7. The CAS/COD/COTH Joint Program on Graduate Medical Education is Tuesday afternoon, November 8, and Wednesday morning, November 9.

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COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 FALL, 1977 VOL. 3, NO. 1

BIOMEDICAL RESEARCH AND RESEARCH TRAINING TASK FORCE. In anticipation of extensive Congressional review of biomedical research and research training authorities during the next legislative session, AAMC has appointed an ad hoc task force to assess and develop policy statements on issues of importance to the academic and scientific communities.

Membership. The task force is headed by CAS Chairman-Elect, Robert M. Berne, M.D., Chairman of Physiology at the University of Virginia. Task Force members representing the AAMC Council of Deans and the AAMC Council of Teaching Hospitals are Theodore Cooper, M.D., Ph.D., Dean, Cornell University Medical School (COD) and Charles A. Sanders, M.D., Director of the Massachusetts General Hospital (COTH). In addition to the chairman, other CAS representatives to the task force include Philip R. Dodge, M.D., Chairman of Pediatrics, Washington University; Harlyn Halvorson, M.D., Director, Rosenstiel Basic Research Center, Brandeis University; David B. Skinner, M.D., Chairman of Surgery, University of Chicago; Samuel O. Thier, M.D., Chairman of Internal Medicine, Yale University; and Peter C. Whybrow, M.B., B.S., Chairman of Psychiatry, Dartmouth.

Timetable. The panel met in early October to study and update previous AAMC policy papers, identify new research policy issues, and develop an issues-and-options paper. After November task force review, the paper will be distributed to the CAS, providing member societies the opportunity to examine it thoroughly prior to the January interim meeting. The task force's final report will be presented to all AAMC councils in March 1978.

For a synopsis of the issues facing the task force, contact Thomas E. Morgan, M.D., Director, AAMC Division of Biomedical Research.

MOVEMENT FOR UPGRADING GRADUATE MEDICAL EDUCATION. A demand for improvement in policies and procedures of review and accreditation in graduate medical education has been on the increase during the past year. Several of the sponsoring organizations of the Liaison Committee on Graduate Medical Education (LCGME), including the AAMC, have concluded that significant headway can be made only if the Residency Review Committees (RRCs) and the LCGME are provided a staff which serves these bodies exclusively and is not subject to the policies of the American Medical Association, which currently provides staffing. The American Board of Medical Specialties (ABMS), at its September meeting, voted to work toward the development of such an independent staff. The ABMS action was subsequently supported by the RRC chairmen.

Simply developing an independent staff for the RRCs and LCGME will not meet the expectations of the certifying boards and the specialty organizations. Both request an upgrading in quality of standards for graduate medical education and of the review process itself so that marginal programs that do not fully meet the quality standards will be eliminated. A new set of General Requirements of the "Essentials of Graduate Medical Education," in draft and currently being circulated for comment, moves in this direction. These General Requirements emphasize the commitment that institutions which sponsor graduate medical education programs must make to assure that their educational responsibilities are met. During the coming year, the movement toward a major reorganization of the accreditation system for graduate medical education will continue to grow.

For a copy of the General Requirements draft, contact August G. Swanson, M.D., Director, AAMC Department of Academic Affairs.

RECOMBINANT DNA RESEARCH LEGISLATION. Seldom in recent years has the biomedical community shown such concern and concentrated action over legislation as it has over the bills which would regulate recombinant DNA research. The Senate bill (S.1217), sponsored by Senator Edward M. Kennedy (D-MASS.), was reported to the Senate floor on July 22. On August 2, Senator Gaylord Nelson (D-WIS.) introduced "an amendment in the nature of a substitute" to S.1217 which is decidedly preferable to the heavy-handed regulation of S.1217, differs from it on a number of major issues, and is believed to have the unofficial endorsement of the NIH. The AAMC, the American Society of Microbiology, and other organizations with unprecedented support of the scientific community contacted every senator to urge support for the Nelson substitute. At this time, Mr. Kennedy has withdrawn S.1217, and the House bill (HR.7897) appears stalled in committee. We will continue our efforts to impress upon the Congress the concerns of scientists until the issue is finally resolved.

AAMC/CAS ANNUAL MEETING. The CAS holds its 11th annual meeting in conjunction with the AAMC's 88th annual meeting November 5-10 at the Washington Hilton Hotel, Washington, D.C. Special CAS sessions are November 7-9.

- CAS/COD/COTH will jointly sponsor sessions on "Challenges in Graduate Medical Education" Tuesday afternoon, November 8, and Wednesday morning, November 9.
- The CAS business meeting is scheduled for Monday afternoon, November 7. Donald Kennedy, Ph.D., Commissioner of the Food and Drug Administration, will discuss the relationship between the FDA and academic medical centers.

THE GOVERNMENT GIVETH AND THE GOVERNMENT TAKETH AWAY. For many years the first \$3600 of research training awards--both direct fellowships and training grants--have been excludable as income for tax purposes. In January 1977, the Internal Revenue Service ruled informally that such awards were fully taxable. The AAMC, through its legal counsel, protested this ruling to no avail, and the IRS has now issued a formal ruling consistent with its former position.

At the same time, the legislative authority lapsed for excluding from taxable income medical student scholarships received under the National Health Service Corps and Armed Forces programs. The result is that these awards are taxable for any student first receiving one after January 1, 1977. Several Congressmen have expressed interest in providing legislative relief for these problems. AAMC will pursue this matter vigorously.

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COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 WINTER, 1978 VOL. 3, NO. 2

CAS MEETS ON BIOMEDICAL RESEARCH POLICY. Representatives of over 40 of the Council of Academic Societies member organizations met at AAMC headquarters in January to consider the draft report of AAMC's Biomedical Research and Research Training Task Force. Prepared by the task force, under the leadership of CAS Chairman Robert M. Berne, M.D., Chairman of Physiology at the University of Virginia, the draft received the general support of the CAS representatives in the day-long discussion of the 21 policy recommendations made in the 22-paged document. Major issues addressed in the paper were

- Support of basic, applied and targeted research;
- Maintenance of a broad base of undifferentiated research;
- Support of applied research;
- Targeted research and the promotion of knowledge transfer;
- Training of research personnel;
- Changes in the management of federal research support;
- Strengthening the institutions which perform research;
- Supporting the peer review system;
- Assuring public participation and accountability; and
- Intrusion of the federal presence into academic institutions.

Members of the AAMC task force will now prepare a final revision, incorporating new suggestions from the session. The revised draft will then go before the AAMC Councils in March. If it is adopted then, the document should be available for distribution in late March. The final policy will guide the AAMC in the preparation of public statements and testimony.

For further information, contact Thomas E. Morgan, M.D., Director, Division of Biomedical Research, AAMC.

MEDICAL SCHOOL APPLICANTS DECREASING. For the first time since 1966, a significant downturn in the number of people applying to medical school has been seen by AAMC's application processing service. The American Medical Colleges Application Service (AMCAS), which is utilized by about 90% of all applicants, has processed 10.4% fewer applicants this year than at this time last year and 12.3% fewer than in the peak year 1975-76. With essentially all applicants now logged in, AMCAS has processed 3,839 fewer individuals than were processed at the same time in 1977. Reasons for this drop are being explored.

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FMG TIDE EBBS. The new exchange visitor (J-visa) requirements for alien FMGs went into effect January 10, 1978. FMGs seeking to enter programs of graduate medical education as exchange visitors now must have passed the new Visa Qualifying Exam (VQE) and an English fluency exam before they can be issued a visa permitting them to enter the country for two years as exchange visitors.

Waivers. A waiver provision permits programs in which an abrupt drop in FMG availability would substantially disrupt medical services to recruit FMGs who have not passed the VQE. Proposed regulations are being developed by the Health Resources Administration which will limit access to opportunities for substantial disruption waivers to programs situated in physician shortage areas and to some specialties which have had a high national proportion of FMG residents. Even under the waiver, programs will not be able to enroll as many FMGs as previously, and the proposed formulae will tend to phase out unqualified FMG entrants by 1980.

Special reviews. Meanwhile, the Liaison Committee on Graduate Medical Education is planning to make special reviews of graduate educational programs which claim that a reduction in alien FMG entrants will disrupt their service functions.

There is a decline in the number of alien FMGs seeking ECFMG certification and, of the 4,618 who took the VQE in September 1977, only 1,163 (25%) passed. It appears that the era of massive influx of FMGs into programs of graduate medical education in the United States is ending.

For further information, contact August G. Swanson, M.D., Director for Academic Affairs, AAMC.

RESEARCH AWARDS TAXABILITY. AAMC continues its efforts to counter the September 6, 1977, Internal Revenue Service ruling that the entire amount of National Research Service Award (NRSA) research training stipends retroactive to 1974 is taxable. The IRS ruling applies only to taxes on research training awards made under the NRSA Act by NIH and ADAMHA and not to awards made under other authorities or by private agencies. Hopes are high that legislation to retain the previous exclusion of up to \$300 per month for a maximum of 36 months will be enacted before April 15, 1978.

Information to provide some guidance for the managers of training programs in advising their research trainees was distributed to CAS official representatives as AAMC Memorandum #78-5 on January 25, 1978, and is available to others upon request.

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

TENTH BIRTHDAY. The fall 1977 Annual Meeting of the CAS marked the 10th year since 16 societies were invited by AAMC to found the CAS. With the election to membership of three societies by the AAMC's legislative body, the Assembly, on November 8, 1977, the CAS membership rose to 63 academic and scientific organizations whose membership totals an estimated 100,000 individuals.

For information on the CAS and how it relates to AAMC programs, contact Mary H. Littlemeyer, Editor, CAS Brief.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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• 1 DUPONT CIRCLE NW
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REVIEW OF THE STATUS OF THE FEDERAL RESEARCH BUDGET. At the end of the Congressional Easter recess, the 1978 legislative year took a hopeful turn. The echoes from President Carter's 1977 recommitment to basic research had hardly died when the NIH budget was unveiled. Despite the President's words, the \$2.885 billion budget proposed for NIH for FY 1979 contained an increase of only \$59.6 million (2.1%) over FY 1978, far less than the amount needed simply to keep pace with inflation. ADAMHA was to be held to an increase of \$69 million (6.8%) over its \$1.010 billion 1978 budget. However, research and research training in ADAMHA were slated to receive a sizeable increase of \$37 million (+21%).

The NIH budget presentation was disheartening because NIH proposed to increase spending for basic biomedical research by \$93 million in keeping with the President's commitment. But NIH proposed to accomplish this increase in basic research by reallocating funds within the budget. As a result, the Administration's proposal would mean that research training, the Biomedical Research Support Program, and applied research (e.g., clinical trials and research contracts) would be the losers of approximately \$52 million.

Some observers were hopeful that the Congress would run "true to form" and adjust the President's budget to higher levels with more funds for clinical and applied research in areas where it was hoped that immediate practical results could be obtained. To some extent, this appears to be true and the Congressional committees have now called for an increase in the budget ceiling for NIH. The House Interstate and Foreign Commerce Committee has recommended increases of \$249 million over the President's budget (specifically for the Cancer and the Heart, Lung and Blood Institutes and for research training). Senate Committees have recommended a \$357 million increase in the budget ceiling to make funds available for all the programs of NIH except the Director's office, the Library of Medicine, and the Fogarty Center. Time will tell how much of these recommended funds the economy-minded budget committees will accept, but the picture is cautiously hopeful.

FACULTY SOLICITATION BY FOREIGN MEDICAL SCHOOLS CATERING TO U.S. STUDENTS. A number of schools of questionable quality have been established in foreign countries and in Puerto Rico, apparently for the purpose of attracting disappointed American students who have not gained admission to a U.S. school accredited by the Liaison Committee on Medical Education. Characteristically, these schools or agencies representing them in this country recruit students by advertising in U.S. newspapers and distributing posters and brochures to premedical advisers. These advertisements build credibility for the school by implying various forms of official recognition--listing in the WHO World Directory of Medical Schools, eligibility for COTRANS, receipt of a charter from the local government--although none of these official-sounding facts stands for accreditation or any other form of review or recognition of educational quality.

Some of these schools are now seeking to add to their credibility by soliciting "visiting professors" from among the faculty of U.S. medical schools. These professorships may consist of nothing more than a few lectures during an all-expenses-paid vacation and the use of the faculty member's name for advertising purposes. U.S. teaching hospitals may also be asked to provide clinical clerkships for students of these schools, either through formal agreement or by informal arrangement with members of the medical staff. In this way, these schools can advertise that they are staffed by U.S. medical school faculty members and that their students can complete their medical education in the United States.

In assessing solicitations from foreign schools or unaccredited domestic schools, U.S. medical faculty and teaching hospitals should exercise due caution. Before lending their names, services, or facilities to these institutions, U.S. faculty members and teaching hospitals should become thoroughly familiar with the quality of the educational experience offered at the foreign institution. They should not allow their names to be used in any scheme to raise false expectations or otherwise exploit American students.

For further information, contact James R. Schofield, M.D., Director, Division of Accreditation, AAMC.

RESEARCH BILLS PROGRESS IN CONGRESS. Both Houses of Congress held hearings on two bills (H.R. 10908 and S. 2450) that would modify the Public Health Service Act with respect to the Cancer and the Heart, Lung and Blood Institutes and research training programs. The Cancer Board will very likely be changed so that its members are appointed--like the other advisory councils of NIH--by the Secretary of HEW rather than by the President. This will strengthen the authority of the NIH Director and draw the Cancer Institute closer to the NIH. The bills also increase the level of authorized funding for the Heart, Lung and Blood Institute.

These bills amend and extend for three years the National Research Service Awards Act (NRSA), the only authority under which research training may now be conducted by NIH and ADAMHA. The Office of Management and Budget (OMB) continues to oppose federal support of research training, particularly institutional training grants. As recently as January 1978, OMB proposed to phase out the institutional training grant programs beginning in FY 1979. AAMC has opposed this action vigorously and, with the support of many academic societies, has persuaded both the House and the Senate to accept the principle that at least 50% of training awards made by NIH and ADAMHA must be made as institutional training grants. Such a requirement has now been written into the law, thus effectively countering the OMB position for at least three years.

In other changes, payback for those Ph.D.s unable to find research or teaching positions after graduation has been made more equitable, and cost-of-living stipend increases have been mandated.

On the subject of taxability of research training grants, the Tax Treatment Extension Act (H.R. 9251) has been amended in the Senate to provide relief for calendar years 1974-1979. However, this measure has been stalled pending the conclusion of the Panama Canal treaty debate. Thus, although it appears that no legislation will be enacted until after April 17, the outlook for final approval remains hopeful.

For further information, contact Thomas E. Morgan, M.D., Director, Division of Biomedical Research, AAMC.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 466-5100

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SUMMER, 1978

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The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

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

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

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

Because this document has received extensive discussion and achieved consensus in all the councils of AAMC, it will be a guide to AAMC staff and representatives who will need to present the Association's views on biomedical and behavioral research to Congress or to federal agencies in the months ahead. For example, the policy statement will serve admirably to guide the Association's response to the initiative of HEW Secretary Joseph Califano described on the next page.

The AAMC Policy Statement will be published soon and will be distributed to members of the AAMC Assembly. Others wishing a copy of the statement should contact, Thomas E. Morgan, M.D., Director, AAMC Division of Biomedical Research Policy.

CALIFANO INITIATES BIOMEDICAL RESEARCH PLAN. HEW Secretary Califano, speaking before the American Federation for Clinical Research in late April, enunciated five principles as the basis of a new five-year plan for federal support of biomedical research:

- o To maintain at a high level and to enhance federal support for fundamental research into biology and behavior;
- o To assure that there are ample opportunities for young investigators;
- o To assure that basic research is accompanied by vigorous, thoughtful, interdisciplinary applications;
- o To assure that government-supported research has a strong orientation toward improving the quality of the nation's health services; and
- o To assure that HEW-supported research is effectively oriented to develop knowledge to support all the health missions of HEW--prevention, delivery, regulation, standard-setting, and cost control.

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

As a result of the Califano speech, NIH is now involved in a comprehensive examination of the federal health research strategy. NIH Director Don Fredrickson has received input from most of the Institute advisory councils and conducted a discussion of Califano's five principles and the five-year research plan with them on June 15 and 16. The NIH is receiving input from other HEW agencies such as the Food and Drug Administration, Center for Disease Control, and Alcohol, Drug Abuse, and Mental Health Administration, and is now synthesizing this into a coherent set of proposed HEW health planning principles. The proposed principles will be presented to a national conference to be held at NIH in late September 1978. Results of the conference will be published in early 1979, public comment will be solicited, and a final five-year plan for the "health research" document will be prepared sometime in mid-1979.

STILL TIME TO CONTACT YOUR CONGRESSMAN. The housestaff unionization bill (H.R. 2222) has not yet been acted upon by the House. There is still time to inform your Congressman that the bill will interfere with graduate medical education.

CAS ANNUAL MEETING. New Orleans Hilton, Monday, October 23, 1978. Paul B. Beeson, M.D., Chairman of the Institute of Medicine Study on Aging in Medical Education will discuss the IOM report.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 466-5100

• 1 DUPONT CIRCLE NW
FALL, 1978

• WASHINGTON DC
VOL. 4, NO. 1

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

SECTION 227 UPDATE. Section 227 of the 1972 Social Security Amendments, P.L. 92-603, establishes special Medicare provisions for paying for professional services provided by physicians in teaching hospitals. While the payment provisions, under current legislation, are scheduled to become effective on October 1, HEW's Health Care Financing Administration (HCFA) has not yet published proposed regulations which would govern the implementation of Section 227. Unless HEW seeks and obtains legislation delaying the date of implementation of Section 227, medical schools, physicians, and teaching hospitals affected by the regulations will not have an adequate opportunity to evaluate and comment on proposed regulations prior to their implementation.

HEW draft regulations. In July AAMC distributed to all constituents copies of the HEW draft regulations to implement Section 227. It also reconvened its Ad Hoc Committee on Section 227, chaired by Charles B. Womer, to examine the draft regulations. The committee had objected strenuously to many of the provisions contained in an earlier draft, considered in April. Despite changes suggested by the AAMC committee then, the July 19 HEW draft included provisions that many teaching hospitals and medical schools find unacceptable to their present educational, medical staff, and patient care practices. For example, the regulations aggravate discrimination against physicians in teaching hospitals; preclude fee-for-service payment where at least 85% of all patients are not private patients; substantially exceed the requirements of the law and discriminate against teaching physicians by imposing unique rules for determining their fees and by penalizing them for previous willingness to treat indigent, medically indigent, and Medicaid patients; threaten the patient's right to obtain private practice care from a fee-for-service physician in a teaching hospital; threaten the organizational viability and fiscal solvency of medical schools and teaching hospitals by decreasing the attractiveness of academic practice, reducing the ability to attract top quality faculty, reducing financial resources available for school support, and reducing admissions and occupancy in teaching hospitals; and create adverse impacts unevenly distributed across the nation depending upon school, hospital, and community characteristics.

Section 227 repeal proposed. A series of events followed which have led, largely through the efforts of the Southern Region medical school deans, to the September 12 proposal for repeal of Section 227 by Senator Bumpers (D-ARK) and 23 cosponsors and similar House action by Representative Tim Lee Carter (R-KY). At its September meeting, the AAMC Executive Council unanimously adopted a resolution supporting Congressional efforts to repeal Section 227.

For more recent information concerning these and other efforts, contact James Bentley, Ph.D., or Richard M. Knapp, Ph.D., AAMC Department of Teaching Hospitals.

GRADUATE MEDICAL EDUCATION TASK FORCE REVIEWS REPORT. The AAMC Graduate Medical Education Task Force has reviewed and approved a report from the Working Group on the Transition Between Undergraduate and Graduate Medical Education. The report recommends that the designator *categorical** be eliminated and that specialty programs offering positions to graduating medical students be designated simply as categorical (C). The report also recommends that the *flexible* first graduate year programs be renamed as mixed or transitional and be institutionally sponsored only by institutions with four or more accredited specialty programs.

For further details and a copy of the report, contact August G. Swanson, M.D., Director, AAMC Department of Academic Affairs.

AAMC PRESENTS TESTIMONY AT NIH HEALTH RESEARCH MEETING. As reported earlier, HEW Secretary Califano has called for a review of the nation's health research apparatus. As part of this process AAMC submitted its recently approved Biomedical and Behavioral Research Policy to NIH and DHEW.

On October 3, 1978 members of the AAMC committee which drafted the policy statement presented AAMC recommendations to four of the five panels organized to receive public testimony on the DHEW Health Research Principles. Harlyn Halvorson, of Brandeis University, addressed the Panel on Fundamental Research. Tom Morgan, AAMC, spoke before the Clinical Applications Panel. Bob Berne, University of Virginia and CAS Chairman, testified before the Research Capability Panel, and Theodore Cooper, Dean at Cornell, presented Unifying Concepts in Support of Research to the Panel organized for that purpose. AAMC expects to participate in the further development of the DHEW plan to support health research.

For further information contact Thomas E. Morgan, M.D., Director, AAMC Division of Biomedical Research.

95TH CONGRESS ADJOURNS IN FLURRY OF ACTIVITY. In the last days of the regular second session of the 95th Congress the usual frenetic pattern of activity occurred. A raft of bills, most of them pending for weeks or months, were passed in the last days of the regular session. One of these was the authority for biomedical research training and the research programs of the Cancer and Heart, Lung and Blood Institutes. The long delays, however, mean that these programs will be funded on a continuing resolution until the Appropriations Committees can act-- probably in March 1979.

At the time of this writing Congress had not finally acted on other bills of interest to the academic community: recombinant DNA research, clinical laboratory improvement, and HR 2222 (housestaff unionization) among others. A good possibility remains that Congress will return for a lame-duck session after the election.

Council of Academic Societies

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

89th ANNUAL MEETING

**"NATIONAL HEALTH PLANNING AND REGULATION:
IMPLICATIONS FOR MEDICAL EDUCATION"**

**New Orleans Hilton Hotel
New Orleans, Louisiana**

October 21-26, 1978

Monday, October 23

1:30 to 5:00 p.m.

Council of Academic Societies
Business Meeting

5:00 p.m.

The Teaching of Geriatric
Medicine in U.S. Medical Schools
Paul B. Beeson, M.D.
Chairman, IOM Committee on the Study
of the Incorporation of Knowledge About
Aging in Medical Education

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 466-5100 WINTER, 1979 VOL. 4, NO. 2

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

PRESIDENT CARTER REVEALS BUDGET REQUEST FOR FY 1980. On January 22, President Carter sent his \$531.6 billion FY 1980 budget request to the Congress. The unveiling of the President's budget for FY 1980 ends a period of speculation and debate which began two months ago when the Office of Management and Budget (OMB) proposed severe cuts for both FY 1979 and FY 1980. OMB proposed, for example, a rescission (an effort by the Administration to cut or eliminate programs already funded by the Congress) of about 10% of the current National Institutes of Health (NIH) budget and recommended that the NIH be funded at this reduced level for FY 1980. Other programs, such as capitation, exceptional need scholarships, and financial distress grants, would have been cut drastically in this fiscal year and eliminated entirely in FY 1980 if the initial OMB proposal had been accepted.

After the OMB submitted its proposal, each department was given the opportunity to defend its current budget and to make recommendations on the 1980 budget. Apparently, DHEW Secretary Califano made a particularly vigorous appeal, arguing that the cuts recommended for NIH were inconsistent with the Administration's stance in support of biomedical research. As a result of Califano's appeal and of strong protestations from Senator Kennedy and other staunch supporters of health programs, many of the proposed cutbacks were restored.

Although the budget picture is not as bleak as had been feared, Mr. Carter will be asking Congress to approve three rescissions which directly affect the academic medical community. The first rescission would cut medical school capitation by 50% this year; the second would reduce the NIH budget by \$37 million--money intended for construction of a child health research facility; and the third would decrease health professions student loans by \$10 million.

Capitation. For FY 1980 the President is requesting no funding for medical school capitation. Secretary Califano told the press recently that capitation encouraged the production of specialists and subspecialists and was therefore being eliminated. He expressed the Administration's opinion that while there may soon be an oversupply of physician manpower, the problem of specialty maldistribution remains. In order to address this problem, the Administration is increasing the budget by \$28 million to support primary care and family medicine training and residency programs.

NIH. The 1980 budget request for the National Institutes of Health, excluding money for buildings and facilities, shows very slight increases over fiscal 1979. This "no-growth" budget will not allow NIH to keep pace with inflation and will, in fact, mean a 7-10% reduction in programs.

Loans and NHSC scholarship program. Also for fiscal 1980, Mr. Carter would eliminate all health professions student loans and increase the budget for the National Health Service Corps Scholarship program by only \$5 million--not nearly enough to meet the need.

(continued)

ADAMHA. The Alcohol, Drug Abuse and Mental Health Administration's budget for 1980 reflects a \$91 million increase over the previous year. Of the \$1.2 billion requested, \$99 million will support a new program of grants to improve mental health service delivery. Approximately \$160 million is requested for mental health research and \$134 million for a new initiative to reduce alcoholism and related problems, particularly among women and youth.

Other new initiatives. In addition to the alcoholism program, the budget seeks two additional initiatives--an increase of \$137 million for preventive health programs and \$194 million for programs to reform the health system. The latter would aim to attract doctors to medically underserved areas, encourage medical students to enter family practice, help communities to eliminate unnecessary hospital beds, and accelerate the creation of health maintenance organizations.

The President's budget, which has been strongly criticized by many as boosting national defense at the expense of health and other "people" programs, is now in the hands of the Congress. Traditionally, the Congress could be depended on to augment the President's recommended budget levels in the health area. But with a new Congress, purported to be more fiscally conservative and intent on reducing the federal deficit, it is difficult to predict the final outcome of the budgetary process.

TECHNICAL STANDARDS FOR MEDICAL SCHOOL ADMISSION. In the Rehabilitation Act of 1973, as amended, Section 504 specifies that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap be excluded from participation in, be denied benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance." DHEW issued regulations implementing this legislation in May 1977. The regulations are detailed and inclusive and could result in medical schools being challenged to admit individuals who have physical or mental handicaps inconsistent with their developing the skills usually expected of all physicians. The regulations provide for the application of nonacademic technical standards in assessing an individual's suitability for admission.

An AAMC panel, appointed last spring, has developed a guide that can be adapted for use by medical schools in framing their institutional policy on nonacademic technical standards for admission.

NEW REGULATIONS AFFECTING CLINICAL RESEARCH ARE ISSUED. The Food and Drug Administration (FDA) has moved to regulate institutional review boards (IRBs) for the protection of human subjects of research. The proposed regulations would add requirements for scientific review and monitoring to the ethical review now required by the DHEW. A storm of protest has arisen, forcing the FDA to extend comment on the regulations by six months to June, 1979. Most observers feel that the FDA should simply adopt existing DHEW regulations.

The DHEW moved suddenly in late November to require that all human subject consent forms be changed to notify prospective subjects as to the availability of compensation for injuries received in the course of experiments. Serious legal objections have been raised to this action. How this new requirement can be implemented, since no compensation insurance is likely to be available, is among questions that remain unanswered.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 466-5100

• 1 DUPONT CIRCLE NW
• SPRING, 1979

• WASHINGTON DC
• VOL. 4, NO. 3

NATIONAL INSTITUTES OF HEALTH 1980 BUDGET. Although the President and the Administration have repeatedly professed an increasing commitment to biomedical research, the President's FY 1980 budget is an unconvincing reflection of a strengthened commitment. The President's FY 1980 budget request of \$3.17 billion for all of NIH, while only slightly below last year's NIH appropriation, would actually mean a 10% reduction in programs due to inflation. In previous years, Congress has always been counted on to appropriate funds for NIH at a level significantly above the President's request, but the pervasive congressional priority to reduce spending may make such optimism unfounded.

In response to the President's budget, Congress has begun the long and complex task of analyzing the budget and developing guidelines for final appropriations. The House and Senate Budget Committees have completed marking up the First Concurrent Budget Resolution which sets nonbinding spending and revenue targets. Both the House and Senate Committees set marks for total discretionary health programs (everything but Medicare and Medicaid) at only about 3% over the President's request. In the fall, the Budget Committees will report a second Concurrent Resolution which will establish binding levels for spending to which the Appropriations Committees must adhere.

Congressional action on the FY 1980 Appropriations bills is proceeding simultaneously with the Budget Committees' deliberations. Both the House and Senate Labor-HEW Appropriations Subcommittees have heard testimony from Administration witnesses and others. The House Labor-HEW Subcommittee expects to mark up the Appropriations bill in mid-May, and the Senate Subcommittee's mark up is expected shortly thereafter. One common theme of the Subcommittee hearings has been how to set priorities for biomedical research if cutbacks in NIH funding are necessary. One of the great concerns this year is the reduction in funds for competing investigator-initiated grants if the budget for NIH is set at or close to the President's request. It is estimated that NIH as a whole could award only 3,062 competing grants in 1980 which would be a reduction from 5,666 in 1979.

Many health interest groups have geared up to defend the NIH budget, stressing the importance of stability in funding for biomedical research. Approximately \$250 million would have to be added to the NIH budget to bring it up to the 1979 level in constant dollars. Unlike previous years, groups concerned with NIH funding are asking for stability in the total NIH budget rather than for increases for individual Institutes, and this united front will undoubtedly be more effective.

Another budgetary problem has arisen which is constrained by the President's hold-the-line 1980 budget. In 1978 Congress authorized the first research training stipend increases since 1974. These stipends have fallen far behind in buying power, and NIH Institute directors are determined to increase both pre- and post-doctoral stipends next year. For example, pre-doctoral students would receive \$5,040 and post-doctorals (first year), \$14,040 annually. The problem is that the Carter budget proposes no increase in the NIH research training budget while about \$35 million additional (\$181 million total) would be required to meet the cost-of-living increases. If the funds are not added by Congress and stipends are increased, at least 1,500 fewer trainees will be supported in 1980 than 1979.

CLINICAL LABORATORY IMPROVEMENT ACT. On March 9, Senator Javits introduced S.590, the Clinical Laboratory Improvement Act of 1979, which appears to be much more of a laboratory "control" measure than its predecessors. After hearing limited testimony on March 16, the Senate Subcommittee on Health and Scientific Research marked up S.590 on March 21. Although the revised bill is not yet available, it apparently includes some modifications of importance to academic medicine. The marked up version of S.590 was approved by the full Senate Committee on Human Resources on April 11. Companion CLIA legislation has not yet been introduced in the House.

The AAMC has appointed an ad hoc committee which will meet in late April to develop Association policy with regard to this legislation.

COMPENSATION OF HUMAN SUBJECTS FOR RESEARCH INJURIES. DHEW's recent move to require that all human subject consent forms be modified to tell prospective subjects of the availability of compensation for injuries received in the course of experiments, was one of several steps recommended by a 1976 DHEW Task Force. Other steps include requiring that compensation for injuries actually be available from the research institutions. The cost of such compensation would, of course, be paid out of available research funds, thus reducing even more the funds available for biomedical research in general.

A working group has been formed consisting of clinical researchers, insurance industry representatives and AAMC staff to find the least expensive and most workable solution to this very difficult question.

NATIONAL BOARD OF MEDICAL EXAMINERS TRANSFER EVALUATION EXAM. The National Board of Medical Examiners has proposed that its Part I exam no longer be used to evaluate students seeking to transfer into U.S. medical schools. As an alternative, the National Board is exploring the development of a separate examination to be used specifically to evaluate transfer applicants.

The AAMC has recommended that the exam be sufficient in scope and depth to evaluate students' knowledge of the basic sciences and the material contained in courses on the introduction to clinical medicine. It has recommended that there not be a passing score and that scores and percentile ranks in each subject area be reported to the medical schools to be used in evaluating transfer applicants. Other AAMC recommendations are that the exam be made available to any individual and that sponsorship by a medical school or by the AAMC, through the Coordinated Transfer System (COTRANS), not be required.

SAME PLACE, NEW NUMBER. Effective May 21, the AAMC will have a new telephone system. Our new central number will be (202) 828-0400.

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 828-0400 SUMMER, 1979 VOL. 4, NO. 4

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

THE RESEARCH OUTLOOK. Although the academic year began on a hopeful note with the President vowing more support for basic research and Secretary Califano enunciating clearly his desire to correct many of the problems about which researchers have been concerned for the past several years, events have not borne out these promising statements:

The NIH/ADAMHA Budget. The fiscal year 1980 budget for NIH and ADAMHA will almost certainly be set at a level below the amount required to keep pace with inflation. If the Carter Administration expected the Senate to follow its traditional pattern of substantially increasing the President's request for biomedical research and medical education, they were as surprised as everyone else when that did not occur. This year, in fact, the House surpassed the Senate in largesse when it came to funding for biomedical research. The House bill, which was approved by the full House on June 26, provides an increase in the total NIH budget of \$202.6 million (6.3%) over last year's appropriation. ADAMHA is funded in the House bill at a level slightly below the 1979 appropriation. An attempt on the House floor to increase the NIH budget to provide additional funds for investigator-initiated grants was unsuccessful. Similar attempts to raise the NIH budget are expected to be made on the Senate side when the bill is marked up in the full Appropriations Committee and on the Senate floor, but these efforts will probably meet with strong opposition. Since the Senate bill is now lower than the House version for NIH and equal to the House version for ADAMHA, it is unlikely that the final Labor-HEW Appropriations bill will provide the necessary inflationary increases for biomedical research.

Decline in Clinical Researchers. A threatened decline in the numbers of MDs entering research training in preparation for academic careers has now become a clear reality. Only 1200 MDs entered postdoctoral research training in 1977 as compared to 3500 in 1974. The number of clinical researchers in the pipeline is far less than the number needed to maintain the national biomedical research effort and to meet the future needs of the medical schools for clinical faculty. The AAMC Executive Council discussed these trends in clinical research manpower at a recent meeting and authorized the immediate formation of an ad hoc committee to formulate a concerted plan to address this problem.

Compensation of Injured Research Subjects. Also in the clinical research area but with wider funding implications for all of biomedical and behavioral research is the threat of DHEW to require that all research institutions provide compensation to human subjects injured in the course of research. A coalition of researchers, university administrators and insurance executives is studying the problem intensively. AAMC has written to Secretary Califano delineating the myriad of unresolved questions in this area and asking DHEW to seriously consider the implications for research institutions if compensation plans are required.

HEALTH SCIENCES PROMOTION ACT OF 1979--(S.988). This bill, introduced in Senator Kennedy's Subcommittee in May, would restructure the Public Health Service Act to enshrine each of the National Institutes of Health in statute; encourage a reduction in paperwork and the administrative burden of research grants; and establish a Council to plan research, to annually critique the President's health science budget, and to provide science advice to the Congress. The goals are praiseworthy but the means proposed to achieve them are questionable. Hearings on the Health Science Promotion Act have been held by Senator Kennedy's Subcommittee, and it is clear that considerable debate is yet to come. Reaction to this legislation has been mixed. While few clinical investigators would disagree with efforts to reduce the paperwork associated with biomedical research, most question the need to extensively restructure one of the few entities of the federal government which has functioned well. Perhaps one of the most widely-held contentions with the bill is the inclusion of sunset provisions for all Institutes except the National Cancer Institute and the National Heart, Lung and Blood Institute. Although the future course of this legislation is uncertain, it will undoubtedly be a bill which is watched with keen interest by the entire biomedical research community.

1979 MEDICAL SCHOOL GRADUATES. In June, approximately 15,000 members of the 1979 graduating class from United States medical schools embarked on their graduate medical education. Based on data from the National Resident Matching Program, 60% of these entered programs in the primary care specialties of family practice (14%), internal medicine (36%), and pediatrics (10%). Six percent chose programs in obstetrics and gynecology. Another 16% entered surgery and surgical specialty programs. The medical specialty programs of dermatology, neurology, and psychiatry took in 4% of the class, and the support specialties 6%. The remaining 8% entered flexible first year graduate positions. This proportional distribution amongst the specialties is about the same as for the graduating classes during the past four years, during which the size of the graduating class has grown by over 2,400.

The Class of 1979, which entered in 1975, was selected from a pool of 42,624 applicants, the largest ever. There were 2.8 applicants for each position. The number of applications has declined each year since. In 1978, 36,636 applicants competed for 16,527 positions, a ratio of 2.2:1. This trend of a decline in the number of applicants is expected to continue. The rapid increase in the number of graduating college seniors has plateaued, and the demographic data for the 80's show a decided downward slope for the number of citizens reaching college age.

ACCREDITATION WORKING GROUP REPORTS. The Working Group on Accreditation of the AAMC Task Force on Graduate Medical Education has completed its work. Its Report, with recommendations for changes in approach to the accreditation of graduate medical education will be distributed to the constituent members of the Council of Academic Societies in the near future. Copies can be obtained by contacting August G. Swanson, M.D., Director, Department of Academic Affairs.

REVISION OF REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION. The Coordinating Council on Medical Education approved a revision of the general requirements for Graduate Medical Education and forwarded it to its parent organizations for ratification. When ratified by the AAMC, AMA, American Board of Medical Specialties, Council of Medical Specialty Societies and American Hospital Association, the revision will become a new standard for accreditation of graduate medical education. It will require institutions sponsoring graduate medical education programs to assume greater responsibility for their quality.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 828-0400 FALL, 1979 VOL. 5., NO. 1

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

NIH ANNOUNCES SHORT TERM RESEARCH AWARDS FOR MEDICAL STUDENTS. Spurred by recent evidence of a disturbing decline in the number of medical students who are interested in research careers, the NIH has mailed to deans an announcement of a new program which will provide, on a competitive basis, a research training program for students in each medical and other professional schools. These new grants will support from 4 to 32 medical (or other professional) students each year for three months of training. An important change is that the students will not be required to pay back the government in research or teaching in return for the experience. Each school will work out the details of its own program which may be in a single department, interdepartmental or school wide. Formal recruiting and research training efforts (e.g., research seminars) must be mounted as a condition of the award and evaluation of impact of the program is highly desirable. Grants will be awarded to those institutions which show the best programs to place highly motivated students in training with those faculty who have the best research and training records.

The grants may be awarded for up to five years and provide \$325 monthly for each student and up to a total of \$750 in institutional training funds. Higher stipends (\$420) may be provided if trainee stipends are generally increased in 1980. The grant is made possible by a 1978 change in the research training authority (NRSA). Applications must be received by November 19 for awards in the Spring of 1980.

APPROPRIATIONS PROCESS TAKES A CURIOUS TWIST. The NIH 1980 appropriations were approved in late summer by both House and Senate at \$3.405 billion, an 8.1% increase over the President's recommended 1980 budget. The apparently successful attempt to sustain the biomedical research budget at levels nearly equal to inflation was dealt an unprecedented blow when the traditional appropriations process defied the new Congressional budget-setting process. Members of the House and Senate Budget Committees were unwilling to "take the blame" for appropriations which exceeded the budget ceilings imposed earlier by the Congress. This led to a confrontation between Senators Muskie and Magnuson, Chairmen of the Senate Budget and Appropriations Committees respectively, and threatened to cut previously passed appropriations bills. This was narrowly averted by the Senate leadership but the scenario has introduced a new reality and uncertainty for the budget process in the future. Meanwhile, as of this writing, final Labor-HEW appropriations are being held up past the beginning of the new fiscal year by the annual debate on what abortions may be paid for by HEW funds.

LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION WILL MAINTAIN ACCREDITATION SYSTEM. The House of Delegates of the American Medical Association approved a recommendation of its Council on Medical Education that the AMA should withdraw from the Liaison Committee on Medical Education. In late July the AMA announced that it was

withdrawing from the LCCME and that it was resuming its accreditation of institutions which provide continuing medical education. The other sponsors of the LCCME, which are the AAMC, The Council of Medical Specialty Societies (CMSS), the American Board of Medical Specialties (ABMS), the Federation of State Medical Boards (FSMB) and the Association of Hospital Medical Educators (AHME) have determined that they will continue the accreditation process which the Liaison Committee has developed during the two years that it has been functioning. This unilateral disruption by the AMA of a liaison committee established for the purpose of involving other professional organizations in the accreditation policies and process for medical education has disturbed many. Of particular concern is an intimation in the Council on Medical Education report that similar action should be considered by the AMA for the Liaison Committee on Graduate Medical Education. For several years the AAMC, CMSS and ABMS has been critical of the support provided to the LCGME by the AMA staff, and have recommended that LCGME have its own staff and that it be financially independent of the AMA. The AMA is in the process of examining its relationship to the LCGME. Should it withdraw and attempt to resume the accreditation of graduate medical education on its own it is likely that the sponsoring organizations of the LCGME will continue the accreditation program which the LCGME has developed with the Residency Review Committees during the past seven years.

AAMC TO WITHDRAW MCAT FROM NEW YORK STATE. In July Governor Carey of New York signed into law a bill requiring agencies administering standardized tests utilized for the evaluation of students for admission to institutions of higher education to file copies of each test for public inspection and provide to students their own answer sheets and the correct answer key. The law's supporters claim that it is intended to protect the interests of examinees. The AAMC, after assessing the potential impact of the disclosure of test materials in the long-term quality and viability of the New MCAT determined that present standards for the development of new questions could not be maintained. Therefore, the Association announced that it will not give the examination in New York State after January 1, 1980. Similar efforts to require disclosure of secure test items are underway in Congress in the form of H.R. 4949 introduced by Representative Weiss (D-N.Y.). H.R. 3564, introduced by Representative Gibbons (D-Fla.) also seeks to regulate testing. Both bills are being considered by the House Subcommittee on Elementary, Secondary and Vocational Education.

These efforts to regulate the standardized tests used for the evaluation of candidates seeking admission to college and professional schools are disruptive and threaten the quality of tests. To date sponsors have failed to produce evidence that the alleged problems are the result of testing or that the benefits claimed will be achieved through the proposed legislation.

H.R. 2222 VOTED OUT OF COMMITTEE. H.R. 2222 was approved by the House Committee on Education and Labor by a 23 to 9 majority. The bill, which would authorize the inclusion of residents as employees in the National Labor Relations Act and permit their unionization for the purpose of collective bargaining, must go to the Rules Committee before being presented to the House. It is important that the academic community continue its efforts to inform the Congress that H.R. 2222, if passed, will jeopardize the teaching-learning relationships between residents and faculty.

AAMC ANNUAL MEETING. The 90th AAMC Annual Meeting will take place at the Washington Hilton Hotel in Washington, D.C. from November 3 to November 8. The theme of the meeting is "The Allocation of Medical Resources and Services: The Role of the Academic Medical Center." The CAS Business Meeting will take place on Monday, November 4.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 828-0400 WINTER, 1980 VOL. 5., NO. 2

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

REPEAL OF SECTION 227 AND CLINICAL LABORATORY LEGISLATION PROPOSED IN HOUSE. On January 31, the House Subcommittee on Health and Environment reported out H.R. 4000-- a series of Medicare and Medicaid Amendments. Two of the amendments, offered by Congressman David Satterfield (D-Va.) and accepted by the Subcommittee, are of particular interest to CAS societies.

Section 227. The first Satterfield amendment would have the effect of repealing the teaching physician payment provisions of Section 227 of the 1972 Social Security Act. During the past eight years, HEW has attempted to implement Section 227 by using a threshold approach to determining whether teaching physicians could be reimbursed on a reasonable charge rather than a reasonable cost basis. Past drafts of Section 227 regulations have stated, for example, that unless a given percentage of all patients in the teaching hospital have a private-patient relationship with a teaching physician, no fees could be billed for professional services in that hospital. These regulations were widely criticized as discriminating against physicians in teaching hospitals and encouraging a return of two standards of patient care among teaching hospitals. The Satterfield amendment to H.R. 4000 would preclude HEW from adopting the threshold approach by overturning the provision of Section 227 which placed physician services on a cost basis unless HEW-specified conditions were met. Thus the Satterfield amendment would essentially repeal Section 227 and would partially resolve academic medicine's long battle over this issue.

Clinical Laboratory Regulation. The second Satterfield amendment would modify and curtail HEW's current approach to clinical laboratory regulation. The impetus for this amendment was two-fold: (1) the widespread concern about the recently proposed "Personnel Standards for Clinical Laboratories" and (2) a section in the Ways and Means Committee version of H.R. 4000 which mandated the application of a uniform quality assurance program, which would include personnel standards, to all classes of laboratories. The Satterfield amendment, while not changing HEW's authority to assure quality in clinical laboratories, directs HEW to use discretion in clinical laboratory regulation. For example, it instructs HEW to (1) only impose such requirements as are found necessary to correct identifiable deficiencies; (2) issue requirements that will be cost-effective and not unduly restrictive of personnel; and (3) take into consideration the different classes of laboratories (e.g., research laboratories).

H.R. 4000 will be considered by the House Interstate and Foreign Commerce Committee in the near future. It is hoped that the Commerce Committee and, subsequently, the full House will act favorably on both the repeal of Section 227 and the limitation of clinical laboratory regulation.

FY 1981 BUDGET REVEALED. In late January, President Carter sent his \$615.8 billion FY 1981 budget request to the Congress. Again this year, the budget request for biomedical research is not adequate to keep pace with inflation. The total NIH

(continued)

budget request is \$3.58 billion which provides only a 4.4% increase over the current year. The ADAMHA budget was set at \$1.26 billion or 6% above the FY 1980 level. With inflation estimated at 10-13%, both NIH and ADAMHA will experience cuts in constant-dollar terms if Congress approves the President's request. One area of major concern in the FY 1981 NIH budget is research training. Proposed expenditures for all types of training will drop from \$176.4 million to \$163.5 million. No new or competing awards are proposed for any of the programs supporting research training including competing training grant renewals but individual awards and training grants already awarded will be funded. This hiatus in research training support is apparently due to the Administration's desire to commit a greater portion of limited funds to its higher priorities--providing stability and adequate funding for investigator-initiated (RO1 and PO1) grants and increasing stipend levels for current research trainees.

Another aspect of the President's budget which is of concern to the medical schools is capitation grants. Not only are no funds requested for medical school capitation for FY 1981, but the President has also requested a rescission of capitation funds for the current year.

GRADUATE MEDICAL EDUCATION: PROPOSALS FOR THE EIGHTIES. This report prepared by the AAMC's Task Force on Graduate Medical Education has been endorsed by the Executive Council and is to be widely distributed for discussion. The report has chapters on The Quality of Graduate Medical Education, The Transition Between Undergraduate and Graduate Medical Education, National Standards Formulation and Accreditation, Graduate Medical Education and Specialty Distribution, and Financing. An invitational conference to consider the report has been scheduled for September 28-29 in Washington, D.C. Specialty boards, specialty societies, other national organizations involved in graduate medical education, health insurance groups, and governmental agencies will be invited to participate. The Task Force, which was chaired by Dr. Jack D. Myers of the University of Pittsburgh, used five different working groups involving over 70 individuals in preparing this major report. Copies will be available in March and will be sent to CAS officers and representatives free of charge. For additional copies send \$3.50 for book rate or \$5.25 for priority mail. There are discounts for orders of six or more.

REPORT OF THE AD HOC COMMITTEE ON CLINICAL RESEARCH TRAINING AVAILABLE. Spurred by the concerns of medical students and academic societies about the decreasing interest and participation of physicians in research and academic careers, AAMC formed an ad hoc Committee on Clinical Research Training in June, 1979. The Committee recommended 32 actions which can be taken by AAMC, medical schools, professional societies and the Federal government to address this problem. For copies of the Report contact Tom Morgan or Diane Plumb at AAMC.

MEDICAL SCHOOL FACULTY SALARIES. The 1979-80 Report on Medical School Faculty Salaries is now available from the AAMC. The Report provides salary percentiles for 29,857 full-time medical school faculty by rank, department and region. Copies may be ordered by sending a remittance or purchase order for \$6.00 to AAMC, Attention: Membership and Subscriptions.

CAS INTERIM MEETING. The 1980 CAS Interim Meeting will be held in Washington on March 18-19. The first segment of the meeting will consist of three small discussion groups on the topics of (1) Health Manpower, (2) Essentials of Research Training Programs, and (3) Development of Policies to Assure an Adequate National Research Effort. The second day of the meeting will include a Plenary Session for reports from each discussion group leader and a Business Meeting.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 828-0400 SPRING, 1980 VOL. 5., NO. 3

The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

PRESIDENT REVISES FY 1981 BUDGET REQUEST. As reported in the last issue of the Brief (Vol. 5, No. 2), President Carter unveiled in January his FY 1981 budget request which was described at that time by Administration officials as lean and anti-inflationary. In late March, only two months later, the President sent a new budget request to the Congress as part of his latest program to combat inflation. The table below shows the revised figures for areas of primary interest to medical school faculty.

	<u>Actual 1980</u> <u>Appropriations</u>	<u>Proposed</u> <u>Rescissions</u>	<u>Revised</u> <u>FY 1980</u>	<u>1981 January</u> <u>Budget</u>	<u>Proposed</u> <u>Cuts</u>	<u>Revised</u> <u>FY 1981</u>
NIH	3,443.0*	-43.2	3,399.0	3,581.5	-91.9	3,490.0
ADAMHA	1,184.0	-69.6	1,115.0	1,261.1	-102.3	1,158.8
Capitation	87.7	-81.3	6.4	-	-	-
HPS Loans	16.5	-16.5	-	-	-	-

*Dollars in millions

For NIH and ADAMHA, the revised President's budget request would mean a reduction in constant dollars of 12% and 15% respectively, assuming a 13% inflation rate. Information is not yet available on how these new reductions will specifically effect funding for investigator-initiated grants or research training. However, the January Administration budget for NIH, analyzed by mechanism of support, would have provided funding for approximately 5,000 ROIs and POIs while providing no money for new or competing renewal training grants or for new individual awards. Therefore, these newly-proposed cuts in the FY 1981 budget will further threaten the critically inadequate training budget and will almost certainly mean that NIH will not be able to "stabilize" research grants at 5,000.

HEALTH RESEARCH ACT OF 1980. Since their inception in 1936, the National Institutes of Health have grown and flourished under the authority of 81 lines of simple, direct language permitting the Surgeon General to "encourage, cooperate with..., render assistance to..., make available..., make grants, secure...assistance, admit and treat...patients, and enter into contracts...in the conduct of research" (Section 301, Public Health Service Act). The beauty, simplicity and flexibility of these stipulations have produced a bureaucratic mechanism admired the world around for its successful support of intramural and extramural biomedical research. The Section 301 authority is not limited in time or in dollar amounts so that only two Congressional committees, House and Senate Appropriations, are required to be involved each year in making funds available for NIH support.

On February 13, 1980 Congressman Henry Waxman (D-Ca.), Chairman of the House Subcommittee on Health and the Environment, introduced a bill that would change all this by establishing the NIH in statute, limiting its authority to three years, setting dollar limits on its appropriations and stipulating in 91 pages what was formerly accomplished in 81 lines. Among the many other problems encountered in this bill is the addition of requirements which would divert research funds to administrative activities, require advisory councils to conduct activities which are at odds with other Federal requirements, and change lines of authority at a time when NIH needs to devote all its attention to averting the effects of austerity on research. The Director of NIH and the Secretary of Health and Human Services have expressed their dismay and opposition but the legislation moved with the speed of an express train through hearings (March 3), subcommittee approval (March 18) and then to a scheduled full committee mark-up (April 2) that was narrowly averted by intensive opposition to the measure. The bill (H.R. 6902) is moving too rapidly to permit careful study and improvement. Cynics suggest that its appeal is the tri-ennial Congressional oversight of NIH which will be required. Many CAS societies have joined to urge a "go-slow" approach to enactment of this bill, suggesting that there are many serious flaws, contradictions and ambiguities that should be eliminated before its passage. A number of Washington based groups are asking Representative Harley Staggers (D-W.Va.), Chairman of the House Interstate and Foreign Commerce Committee, to hold additional hearings and discussions to perfect the legislation and to remove the most objectionable of its ill-considered, inappropriate provisions. The postponement of the April 2 mark-up by the full committee hopefully provides an opportunity to hold these discussions and perfect or defer the legislation.

AMERICAN COLLEGE OF SURGEONS PROPOSES CHANGES IN RESIDENCY ACCREDITATIONS. For several years there has been a growing debate about the accreditation system for graduate medical education. The debate is centered around the roles and relationships of residency review committees, the Liaison Committee on Graduate Medical Education (LCGME), and the professional societies which sponsor residency review committees and the LCGME. In February, the American College of Surgeons (ACS) distributed a proposal for a new mechanism to approve and accredit graduate education programs in the surgical specialties. The proposal calls for a self-supporting accreditation system with an independent staff. It recommends that residency review committees be restructured and their sponsorship changed to a specialty board and a specialty society and that the American Medical Association representation in graduate medical education be only through the Liaison Committee on Graduate Medical Education. The residency review committees would function essentially independently from the LCGME which would play only an advisory role and be an appeals body.

In March, the Graduate Medical Education Committee of the Council of Medical Specialty Societies (CMSS) held meetings in conjunction with the CMSS Spring meeting. Agreement was reached amongst the societies (including the ACS) on twelve points which incorporate the ACS proposals for independent financing and staffing and residency review committee reorganization but retain a closer relationship between the residency review committees and the LCGME. The Graduate Medical Education Committee's report will be on the CMSS agenda at its July meeting. It presumably will then be distributed to other sponsors of residency review committees and the LCGME for consideration.

CAS INTERIM MEETING HELD

The CAS Interim Meeting was held at the Washington Hilton Hotel on March 18-19, 1980. Sixty-four individuals from 50 of the 69 member societies were present to participate in discussion groups, followed by a plenary session at which Senator Richard S. Schweiker (R-Pa.) delivered the keynote address. The next CAS meeting will be held in Washington at the Washington Hilton on October 26-27, 1980.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
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The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

STATUS OF NIH AUTHORIZING LEGISLATION. As reported in the Spring issue of the Brief (Vol. 5, No. 3), the Health Research Act of 1980, now numbered H.R. 7036, was introduced by Congressman Waxman (D-Ca.) in late February and has moved through hearings, Subcommittee mark-up, and Committee mark-up. Several important changes have been made in H.R. 7036, but the most objectionable provision of the bill remains--the deletion of the general and flexible authority for NIH which existed in Section 301 of the Public Health Service Act and the substitution of short-term authorizations with appropriations ceilings for all of the Institutes. In 1944, the Congress provided permanent authority for the research activities of NIH that were then in existence as well as for those to follow. Except for the Cancer and Heart Acts in the early 1970's, the Congress has chosen to leave this successful arrangement in place. The chief source of opposition to changing the existing arrangement now stems from the belief that there is no compelling reason to meddle with a system that has been proven to work. In austere times, Congressional supporters of the bill contend NIH funding will fare better with yearly authorizations. This argument is not convincing because authorizations are, in fact, maximum spending ceilings which actual appropriation cannot exceed. An additional concern is that future routine reauthorization might be held hostage to unrelated and more controversial legislative objectives (e.g. National Health Insurance, abortion).

As originally drafted in 1979, the Senate biomedical research bill (S. 988) established similar authorization limitations for all Institutes. Because of widespread objection, these limitations were removed from S. 988 and the permanent authorities for NCI and NHLBI were reaffirmed. A major provision of S. 988 that is not contained in the House bill is the establishment of a planning council on the health sciences. S. 988 passed the Senate on June 19 by a vote of 82 to 0.

At this time, the House bill is awaiting floor action. If H.R. 7036 is approved by the House, both bills will have to be conferenced to meld the distinct provisions of each into one bill.

COMPREHENSIVE QUALIFYING EVALUATION PROGRAM. In 1973 the Goals and Priorities (GAP) Committee of the National Board of Medical Examiners recommended that the Board develop an examination to evaluate whether medical students had acquired the knowledge and skills needed to enter the graduate phase of their medical education. The National Board staff has been engaged in research and development of such an examination and has expanded the concept to include obtaining evaluations of students' competencies from medical school faculties. The endeavor is called the Comprehensive Qualifying Evaluation Program (CQEP). At their annual meeting in March, a prototype of the proposed exam was exhibited to Board members. The vast majority of items are from existing Parts I, II, and III questions. The development of a unique set of items to evaluate students' understanding of the scientific basis of clinical medicine has only recently been undertaken. AAMC representatives to the Board expressed concerns that unless the academic faculties are fully apprised of the characteristics and utility of the CQEP, a potential negative reaction similar

to that which arose to the original GAP Committee proposal might occur. They urged the development of a plan for greater involvement of faculties in an assessment of the prototype exam and the program

In a related development, the Federation of State Medical Boards has proposed that states require a two-phased licensing procedure. Passing the first phase would qualify a newly graduated physician to care for patients in a supervised educational setting. This limited license would require passing an examination called the Federation Licensing Exam I (FLEX I). Full licensure for independent practice would be granted only after two or more years of graduate medical education and would require passing a second examination (FLEX II).

The Federation has indicated that FLEX I could be the Comprehensive Qualifying Exam and the National Board has indicated a willingness to provide the CQEP to be used by the Federation as FLEX I. Unresolved is whether the Federation would control the policies regarding the content, weighting and scoring of the examination or whether these policies would be retained by the National Board. Were the Federation to assume policy control for FLEX I, as it currently does for the FLEX exam, the control of the content and characteristics of the CQE would be removed from the academic community. Since the NBME has, from its inception, had a unique collaborative relationship with the nation's medical school faculties, there is the possibility of an adverse impact on the role and function of the Board in the future.

The Executive Council of the Association has appointed a special Ad Hoc Committee to review the issues raised by the development of the CQEP and the Federation's proposed FLEX I examination.

RADIATION WASTE FROM BIOMEDICAL RESEARCH LABORATORIES AND HOSPITALS. The 1979 closure of the national sites for disposal of radioactive wastes focussed attention on the instability of the disposal problem. Federal inactivity and conflicting agency rules combined to prompt AAMC to mount a private sector effort to address this problem. The result, a paper containing five recommendations for biomedical institutions and the Federal agencies, has been accepted by President Carter's new Radiation Policy Council as one of its highest priorities for study. Contact Tom Morgan for a copy.

GENERAL REQUIREMENTS OF ESSENTIALS MOVE CLOSER TO RATIFICATION. In 1977 the Liaison Committee on Graduate Medical Education (LCGME) appointed a committee to rewrite the General Requirements section of the Essentials of Accredited Residencies. After extensive debate, a conference committee composed of LCGME representatives and Coordinating Council on Medical Education representatives who were designated by each of the five sponsoring organizations, has agreed upon a draft which will be forwarded first to the LCGME for approval and then to the CCME for ratification by the sponsoring organizations. If the new General Requirements section is ratified, institutions sponsoring graduate medical education programs will be required to develop internal quality control and evaluation systems for their programs. Among other modifications, the designation of program types will be changed from categorical, categorical*, and flexible to simply categorical and transitional.

UPDATE ON CLINICAL LABORATORY REGULATION. Activities in this area have shifted for the time being from the Congress to the Department of Health and Human Services. More than 7000 protests were received on its 1979 proposed personnel standards based on educational credentials. As a result of these protests and a June 9-10 hearing in Atlanta, the Department seems likely to exempt clinical research laboratories and possibly specialty laboratories from revised regulations. The AAMC, affected teaching hospitals and clinical specialty societies must continue to press for more effective and less costly and less obtrusive alternatives to credentialing for laboratory quality control.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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LEGISLATIVE UPDATE. On October 3, Congress adjourned leaving the following unresolved legislative issues of concern to the biomedical community:

- Biomedical Research Authorizations - Both the House and Senate have now passed bills (H.R. 7036 and S. 988) which would create a statute for NIH. H.R. 7036 requires re-enactment of NIH authorizations every three years, limits spending and makes other changes not provided in S. 988. Senator Kennedy, at the urging of the biomedical research community, is holding fast to the Senate bill's provisions. Citing irreconcilable differences, Senator Kennedy refused to conference the bills with Congressman Waxman before adjournment but a conference remains a real possibility in the lame duck session.
- Tax Exemptions for Scholarships - In the last week of legislative action prior to adjournment provisions to provide tax exemptions for scholarships for medical education and for research training were removed from the 1981 omnibus tax package. It is still possible, however, that Congress will pass legislation this year to provide an exemption for the tuition portion of military medical and National Health Service Corps scholarships and a one-year extension of the moratorium on taxation of National Research Service Awards.
- Institutional Educational Support - The renewal of the Health Professions Education Assistance Act of 1976 has not yet been accomplished by the Congress. The health manpower bills passed by each house (S. 2375 and H.R. 7203) are quite different. H.R. 7203 continues capitation support, requires that 50 percent of filled first year residency positions be in primary care, and phases down federal institutional educational support over three years. The Senate bill provides an innovative new National Priority Incentive Grant Program. A grant of \$250 per student enrolled is provided for meeting six national priorities (e.g. increasing the number of students entering primary care careers, developing school programs to attract students to clinical investigation careers). Institutions may opt to meet none or all of the designated priorities. This proposed Senate program continues federal support for medical education, but changes the incentive from class size expansion to other national priorities. AAMC supports the Senate bill. There are many other differences between the two bills which must be resolved by a conference committee during the lame duck session following the election. Therefore, it is unclear whether a Manpower Act will emerge from this Congress.
- The 1981 Federal Budget - The perennial argument about the use of funds for abortion and other factors prevented passage of the Labor-HHS and VA budgets. On October 1, after the fiscal year began, Congress passed a continuing resolution which permits continued federal spending at the 1980 level or at the House-passed 1981 figure, whichever is lower. Depending on the election results, it is possible that a final budget may not be passed until after the new Congress begins.

ACCREDITATION COMMITTEES REORGANIZED. Conferences among the top officials of the organizations sponsoring the Coordinating Council on Medical Education and the accreditation liaison committees during the summer of 1980 resulted in an agreement to reorganize the accreditation system. The conferees agreed that the Coordinating Council on Medical Education had failed to be a forum for resolution of medical education policy issues and had been an impediment to the liaison committees responsible for the accreditation of graduate medical education and continuing medical education. It has been abolished. There will be a Council for Medical Affairs (CFMA) comprised of the two top elected officers and the chief executive officers of the American Board of Medical Specialties, the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. This council will provide a forum to consider issues related to medical education and other matters of mutual concern. The CFMA will not be directly involved with the accreditation committees and accreditation policies.

The Liaison Committee on Medical Education which accredits undergraduate medical education programs will not be changed in membership or operation. It will continue to be co-sponsored by the AAMC and AMA. However, the two liaison committees which were organized during the 1970's will be replaced by two new accrediting councils.

The Accrediting Council for Graduate Medical Education (ACGME) will have four representatives each from the five sponsoring organizations of the CFMA plus a resident, public and non-voting federal representative. The Council will have the authority to accredit graduate medical education programs but may delegate that authority to a residency review committee (RRC) on request for a specified period. The RRC will have to conform to ACGME policies and procedures in its accreditation activities. The ACGME will monitor and periodically review RRCs which are granted accreditation authority. The ACGME will be responsible for developing and operating the system for appealing accreditation decisions.

Staff services for the ACGME and RRCs will be provided by the AMA under conditions specified by a letter of agreement. The cost of accreditation activities will be paid for by revenues generated from charges to programs. The sponsoring organizations will equally bear the cost of ACGME activities related to policy development.

Unanimous approval by all sponsors will be required only for the general essentials and bylaws. Fiscal policies and new programs may be subjected to unanimous approval on the request of one sponsoring organization.

The LCCME will be replaced by an Accrediting Council for Continuing Medical Education (ACCME). Each of CFMA's sponsors will have three representatives. The Association of Hospital Medical Educators and the Federation of State Medical Boards will each have one representative. There will be a public and non-voting federal representative. Authority for accreditation of intra-state programs will be granted to state medical associations or consortia. Inter-state continuing medical education programs and those sponsored by medical schools will be accredited by the ACCME. The CMSS will provide staff services to the ACCME. Approval of policy issues will be the same as for the ACGME.

This reorganization and the agreements on policies and procedures should alleviate many of the conflicts that have beset the accreditation system. All sponsoring organizations are dedicated to their effective implementation.

CAS FALL MEETINGS. The CAS Fall Meetings will be held in Washington on October 26-27, 1980. A Forum on Faculty, plenary session, and discussion groups will be held on October 26. The CAS Business Meeting will take place on October 27, featuring a presentation by Dr. Jules Hirsch, Professor and Senior Physician, Department of Human Behavior and Metabolism, Rockefeller University.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
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HEALTH BUDGET. Prior to the change of Administrations, President Carter submitted to Congress a budget request for FY 1982 and a request for funds to be rescinded from the current year (FY 1981) budget. A "rescission" is the mechanism provided by the 1974 Budget and Impoundment Control Act that allows a President to appeal to Congress to take back funds already appropriated for use in the current fiscal year. Congress has 45 days in which to approve a rescission request. This year, President Carter asked for a rescission of \$334 million from the HHS budget, all but \$10 million of which would be taken from the Public Health Service. Among other things, the Carter Administration advocated a rescission of: 1) all capitation funds, 2) \$77 million in Alcohol and Drug Abuse formula grants, and 3) \$50 million of the \$126 million increase the NIH was granted for this year. Areas that would be particularly hard hit within NIH if the rescission receives Congressional approval include: research centers, R&D contracts, Basic Research Support Grants, and the intramural program.

The Carter Administration's proposal for next year's budget requests approximately an 8% increase for ADAMHA and a 7% increase for NIH as a whole. Carter Administration priorities that are reflected in the budget are stability in research grant funding and maintenance of the current training effort. Funds are provided in the NIH budget for 5,000 investigator-initiated grants and for training approximately the same number of trainees as were supported last year. Obviously, with a total increase for NIH held considerably below the inflation level, the NIH programs cited above bear the brunt of the budget squeezing anticipated for FY 1982.

Within the next few days, the Reagan Administration will release its budget package for FY 1982. Considering the well-publicized intention of the new Administration to decrease Federal spending and the difficulties inherent in controlling the entitlement programs that comprise 90% of the health budget, it is anticipated that health education and research programs in general may be in serious jeopardy. There are reliable rumors currently circulating that President Reagan will propose sizeable further rescissions in the NIH budget. It is understood that this Administration is also committed to protecting the stability of ROIs and POIs and that research training will, as a consequence, be the target for the additional rescissions. If these rumors are substantiated when the Reagan budget is made public and if the viability of research training is indeed threatened, CAS members will be immediately notified.

AAMC RESPONSE TO THE GMENAC REPORT. The AAMC has distributed its response to the Report of the Graduate Medical Education National Advisory Committee to the Council of Academic Societies, Council of Deans, Council of Teaching Hospitals, and Organization of Student Representatives. The response focuses on the major issues of concern to academicians and their institutions. For a copy of the response, contact Lynn Gumm, Administrative Secretary, AAMC at 202-828-0482.

1981 INTERIM MEETING — FEBRUARY 26-27

NRSA RENEWAL. The National Research Service Awards (NRSA) Act, which provides the legislative authority for the NIH research training program, is due to expire in the fall. In order to avoid a hiatus in research training support, the health authorizing committees in the House and Senate must complete their work on the renewal legislation by May 15. Since nearly all research training in the country is supported by NRSA, it is critically important that this legislation is renewed. Congressional staffers who will work on this issue do not presently anticipate major problems with the continuation of NRSA's but warn that all legislation will be closely scrutinized by the budget-conscious new Congress. One of the provisions that may be re-examined during Congressional consideration of the NRSA Act is the controversial payback clause with an eye towards minor modifications that would make this provision less of a deterrent to MDs considering research training.

NEW CONGRESS AND ADMINISTRATION. The new leadership in the Congress and in the Administration is beginning to coalesce. In the new Republican-dominated Senate, two key figures will be Harrison Schmitt from New Mexico as Chairman of the Senate Subcommittee on Labor-HHS Appropriations and Orrin G. Hatch (Utah) as head of the Labor and Human Resources Committee. The health subcommittee that formally was a substructure of the Labor and Human Resources Committee has been abolished, and health issues will be dealt with by the full Committee. Senator Edward Kennedy has become the ranking minority member of this committee. On the House side, Henry Waxman (California) will continue as the Chairman of the Interstate and Foreign Commerce health subcommittee with Edward Madigan (Illinois) replacing Tim Lee Carter who retired last year as the ranking minority member. William Natcher (Kentucky) will continue to chair the House health appropriations subcommittee.

Appointments are being made almost daily to top positions in Secretary Schweiker's Department of Health and Human Services but the precise hierarchy and titles are not yet clear. David Swope will serve as the Department Under Secretary or Deputy Secretary. Formerly director of the California Department of Social Welfare, Swope is currently legislative director for Senator William Armstrong (Colorado). The chief health position in the Department will be filled by Edward Brandt, Jr., MD, PhD who has been the Vice Chancellor for Health Affairs at the University of Texas at San Antonio. Reporting to Dr. Brandt and having responsibility for the health agencies will be Charles Koop, M.D., a pediatric surgeon from the University of Pennsylvania. Carolyn Davis, former dean of the nursing school and now associate vice president for academic affairs at the University of Michigan, is expected to be appointed administrator of the Health Care Financing Administration. Top agency positions such as head of FDA and ADAMHA remain unfilled at the moment.

1980-81 CAS ADMINISTRATIVE BOARD. At the October 1980 Meeting of the Council, Dr. David Brown was elected CAS Chairman-Elect. Dr. Brown is a Professor of Pediatrics and Laboratory Medicine at the University of Minnesota and is a Representative of the Academy of Clinical Laboratory Physicians and Scientists. New Board members also elected at the October meeting are: Dr. William F. Ganong, Chairman of the Department of Physiology at UC-San Francisco and a Representative of the Association of Chairmen of Departments of Physiology; Dr. Brian A. Curtis, Associate Professor of Physiology at the University of Illinois and a Representative of the American Physiological Society; and Dr. John B. Lynch, Chairman of the Department of Plastic Surgery at Vanderbilt University and a Representative of the American Society of Plastic and Reconstructive Surgeons. Re-elected to the Board was Dr. Robert L. Hill, Chairman of the Department of Biochemistry at Duke University and a Representative of the Association of Medical School Departments of Biochemistry.

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PROPOSED RESEARCH TRAINING CUTBACKS. In an unexpected move, the Reagan Administration has proposed to rescind \$59.5 million from the NIH research training budget for the current year. Congress had approved, and NIH was operating on, a training budget of \$194.4 million. Thus, Administration proposals, if accepted by Congress, would reduce the 1981 research training budget by 31%. OMB Director David Stockman said this reduction would be accomplished by removing all institutional allowances and the 8% indirect cost recovery rather than by reducing numbers of trainees.

Institutional allowances are used to pay for trainee travel and laboratory costs, to buy books, and to support partially the training program directors. They were instituted by NIH and Congress to enable institutions to provide a richer training environment than is possible on a program of fellowships alone. Veteran Hill staffers were amazed at the cleverness of the OMB move but not surprised given the implacable opposition of OMB to Federal support of biomedical research training.

In related actions, Congress prepares to review the research training authority (National Research Service Awards) which expires this year. It came as no surprise that the Republican-controlled Senate health Committee's NRSA bill (S. 800) provides a research training authorization of only \$150 million--a level consistent with the OMB proposal to cut research training. It was very surprising, however, when Congressman Henry Waxman introduced a House NRSA bill that also accepts the Republican Administration's reduced funding ceiling for training.

FEDERAL BUDGET PROPOSALS FOR FY1981 AND FY1982. Budget and Appropriations Committees in both Houses of Congress are diligently working out details of Federal spending levels for the current fiscal year and for next year. The Senate Budget Committee adopted a budget resolution (Senate Concurrent Resolution 9) that was subsequently approved by the entire Senate. The Senate resolution directs the appropriating and authorizing committees to reduce spending this year by \$14.7 billion and recommends extremely meager spending levels for the next two years. The passage of this bill in the Senate puts enormous pressure on the Senate Appropriations health subcommittee to approve the President's rescission requests for NIH and other programs of importance to the medical schools and to reduce drastically spending for controllable health programs next year.

In the House, there appears to be a higher degree of skepticism that health, education and other so-called people programs must be sacrificed in order to restore economic well-being in the country. On April 6, House Budget Committee Chairman Jones proposed an alternative Federal budget. Representative Jones indicated that his proposal supports "our national investments in human capital--in education and skills and health." When the House Budget Committee marked up its resolution, which will be voted on in the House shortly, it recommended partial restoration of many of the proposed rescissions and funding reductions for programs of interest to the medical schools. The House Appropriations health subcommittee just recently considered the FY1981 rescissions, and although the results have not yet been made public, it is understood that the Subcommittee did not approve all the rescissions requests, particularly in the research and research training areas.

1981 FALL MEETINGS—NOVEMBER 1-2—WASHINGTON, D.C.

SINGLE ROUTE TO LICENSURE CREATES CONTROVERSY. The proposal by the National Board of Medical Examiners and the Federation of State Medical Boards that there be a single route to licensure through a sequence of two examinations has generated discussion and controversy. The NBME has had a Comprehensive Qualifying Examination (CQE) under development for the past several years and the Federation has made a preliminary commitment to have the CQE be the first examination in the sequence (FLEX I).

At a presentation by the National Board at the 1981 CAS Interim Meeting, it was evident that the CQE cannot evaluate the technical skills, interpersonal skills and attitudes that faculties of accredited U.S. medical schools evaluate repeatedly by direct observation of a student's performance. The proposition that passing the FLEX I will assure that graduates are competent to care for patients in a graduate medical education programs is open to serious question.

Acting on the advice of the CAS Administrative Board, the AAMC's Executive Council has requested that the Federation and the National Board not proceed with the implementation of the proposed two examination sequence for licensure. An ad hoc Committee, chaired by Carmine D. Clemente, Ph.D., former chairman of the CAS, is developing an alternative proposal to ensure that graduates of schools not accredited by the Liaison Committee on Medical Education meet educational achievement and professional preparedness standards equivalent to those met by graduates of U.S. medical schools. For further information, call August G. Swanson, M.D., Director of the Department of Academic Affairs at 202-828-0430.

HOUSE AND SENATE MANPOWER BILLS INTRODUCED. In late February, Representative Henry Waxman (D-Ca), chairman of the health subcommittee, introduced H.R. 2004 which is essentially the same health manpower bill that passed the House last year by an overwhelming margin. One month later, Senator Orrin Hatch (R-Ut), chairman of the Senate health committee, introduced S. 799--a manpower bill that calls for a reduction in Federal support for medical education. The House and Senate proposals are markedly different: the House proposal is generally supportive in most areas of importance to medical schools and their students; the Senate proposal is very stringent and terminates or greatly reduces support for medical education programs.

H.R. 2004 reauthorizes with minor revisions the current health manpower law with the major exception that it phases out medical school capitation. The proposed phase out would mean that schools would receive approximately \$400 per student in FY1982, \$200 per student in FY1983, and no capitation support in FY1984. The House bill continues support for the existing special project grant program and includes generally favorable student aid provisions.

S. 799 terminates medical school capitation and greatly reduces support for several programs of importance to the medical schools: primary care residencies, area health education centers, departments of family medicine, and assistance for students from disadvantaged backgrounds. The Senate bill limits access and funds for student financial aid. If the Senate bill's student aid proposals were adopted and coupled with the Reagan Administration's plan to limit access to Guaranteed Student Loans, medical students would be forced to turn to the high-interest HEAL loan program, now running at 18%, and would not have the option currently available for some HEAL borrowers to consolidate their loans at a more reasonable interest rate.

GENERAL REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION RATIFIED. After five years of debate, a revision of the General Requirements of the Essentials of Accredited Residencies has been ratified. The revision requires greater institutional accountability for the quality of sponsored graduate medical education programs than do the previous requirements. The ACGME has also provided the authority to determine the examination standards that are acceptable for graduates from foreign schools to be eligible to enter accredited graduate medical education programs. Copies of the revised General Requirements are available by writing to the Secretary of the Accreditation Council for Graduate Medical Education, 535 North Dearborn Street, Chicago, Illinois 60610.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 828-0400

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CONGRESS ADOPTS RECONCILIATION BILL. The long and complex reconciliation battle finally ended in late July when Congress adopted a final Omnibus Reconciliation Act calling for cuts of \$8.5 billion in health programs over the next three years. In most cases, programs important to medical school faculty fared as well or better than expected considering the extremely austere Senate approach to most of these programs and the early predictions that the health conference committee would be hopelessly deadlocked over widely disparaging House and Senate positions on crucial issues.

One of the most troubling proposals on the Senate side--establishing an overall funding ceiling for the NIH, the NIMH, and other Federal health agencies--never came to fruition. The conference committee fortunately accepted the House approach of re-authorizing programs within these agencies, thus negating the "cap" approach. Provisions of the bill in areas of particular interest to faculty are:

Research Training: The NRSA program is reauthorized for two years with a funding ceiling of \$182 million in FY82 and \$195 million in FY83. If money is appropriated at this ceiling in FY82, NIH is likely to receive about \$164 million--\$12 million below the current NIH training budget. How this decrease will affect numbers of trainees or the size of institutional allowances is left up to the discretion of DHHS, with the caveat that neither is to be significantly reduced.

Student Aid: The bill includes reauthorization of Health Professions Student Loan programs for the next three years at \$12, \$13, and \$14 million. The Exceptional Financial Need Scholarship program was retained and authorization was provided for new starts in the National Health Service Corps. The Health Education Assistance Loan program was reauthorized for three years at \$200, \$225, and \$250 million.

Medicaid: The Medicaid "cap" concept was rejected, but Federal matching payments to states will be reduced by 3%, 4%, and 4.5% in the next three years.

The next hurdle in the process of gaining adequate support for medical research and education programs will be in the Appropriations Committees where final spending authority is decided. In September, these committees will begin marking up their bills, working within the tight guidelines imposed by the First Concurrent Budget Resolution. Since competition for shrinking Federal support will be intense, the academic medical community will have to be particularly compelling in urging full funding of medical education and research programs.

AAMC REPORTS FOCUS ON PREPARATION FOR GRADUATE MEDICAL EDUCATION AND EVALUATION FOR LICENSURE.

The AAMC's Executive Council adopted two important committee reports at its June 25th meeting. "External Examinations for the Evaluation of Educational Achievement and for Licensure" and "Quality of Preparation for the Practice of Medicine in Certain Foreign-Chartered Medical Schools" are complementary documents that focus on the issues raised by the Federation of State Medical Boards' proposal to require all candidates for entry into graduate medical education to pass a preliminary licensure examination (FLEX I) and a later licensing examination (FLEX II) for an unrestricted license to practice.

1981 FALL MEETINGS—NOVEMBER 1-2—WASHINGTON, D.C.

Concerns have been expressed about the readiness of medical school graduates-- particularly those of foreign-chartered schools--to continue into graduate medical education. The report on external examinations points out that the critical evaluations of clinical skills and personal professional qualifications required of students in LCME accredited schools are not known to be required of students in non-LCME accredited schools. Evaluation of these essential qualities, which are not easily measured by written examination, is a responsibility of U.S. medical school faculties.

The reports urge that the Federation of State Medical Boards not require passage of the FLEX I examination (the preliminary examination at the interface between graduate and undergraduate medical education) by graduates of LCME accredited schools. They recommend that for the purpose of ensuring adequate evaluation of graduates of non-LCME accredited schools at this stage, the Accreditation Council for Graduate Medical Education (ACGME) should request the Educational Commission for Foreign Medical Graduates (ECFMG) to apply more appropriate evaluation methods and raise its standards for determining the educational preparation of these individuals. The proposed methods are: (1) a rigorous written examination equivalent to Parts I and II of the National Board of Medical Examiners certification sequence followed by (2) a practical hands-on evaluation of clinical skills in prepared testing centers. For graduates of LCME accredited schools, final licensure for unrestricted practice still would require either passing the NBME Parts I, II and III examinations or the FLEX examination. For graduates of non-LCME accredited schools, passing the FLEX examination would be required.

The Association's Executive Committee has met with representatives from the Federation of State Medical Boards and discussions to resolve the concerns of the academic community are in progress. The Accreditation Council for Graduate Medical Education has referred the question of modifying the evaluation methods and the standards for ECFMG certification to a standing committee.

Copies of both reports have been distributed to CAS society representatives and officers. Additional copies are available by writing August G. Swanson, M.D., Director of the Department of Academic Affairs. Societies are urged to inform the Federation of State Medical Boards, the ACGME, and the ECFMG of their views and to send copies of such communications to Dr. Swanson.

1981 CAS FALL MEETINGS. The 1981 CAS Fall Meetings, held in conjunction with the AAMC Annual Meeting, will begin on November 1 with an afternoon program devoted to discussion of the issue of basic science education as the foundation for advanced medical practice. Dr. Frederick E. Shideman, Chairman of the Department of Pharmacology at the University of Minnesota, will contrast the content and scope of instruction in pharmacology in 1960 compared to 1980 and speculate on changes that may occur in this area by 1990 as a result of the virtual explosion of basic science knowledge currently underway. Dr. Rubin Bressler, Chairman of the Department of Medicine at the University of Arizona, will address the challenge of selecting the essential basic science knowledge students should learn during this period of rapid scientific advancement and change when it is difficult to identify concepts which will remain relevant for future practitioners of medicine. These presentations will be followed by small group discussions on underlying topics. On November 2, Dr. Robert W. Berliner, Dean of the Yale University School of Medicine, will discuss science in medical practice in the year 1990. The CAS Business Meeting, including election of officers and Administrative Board Members, will also be held on November 2.

COMPETITIVE APPROACH TO CONTAINING HEALTH CARE COSTS. At its March meeting, the AAMC Executive Council approved a discussion paper entitled "Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals." Copies may be obtained by sending \$3.00 to the AAMC Office of Membership and Subscriptions. Also currently available, at a price of \$3.00, is a booklet prepared by the Association's Department of Teaching Hospitals: "Toward a More Contemporary Public Understanding of the Teaching Hospital."

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

VITALITY OF BIOMEDICAL AND BEHAVIORAL RESEARCH THREATENED BY FUNDING REDUCTIONS AS WELL AS LEGISLATIVE PROPOSALS

The Federal budget for research and research training has in recent months occupied the full attention of faculty members and others in academic medicine who are concerned about the vitality and stability of the biomedical and behavioral research enterprise. The scientific community's preoccupation with funding levels for research programs has been engendered by a single-minded determination in Washington to cut Federal spending for all non-defense programs with virtual disregard to the nature and importance of the programs being sacrificed.

Fortunately, several Members of Congress have recognized that biomedical and behavioral research is an investment that the public strongly favors and that it is particularly vulnerable to demise if it is not supported in a stable and adequate fashion. With the support of these Congressional proponents, the academic medical community was fairly successful in staving off the funding reductions proposed early in the year in the form of rescissions and, more recently, in the form of reconciliation measures. But, unlike previous years, the defeat of one version of a proposed cutback has not meant that research support can be reasonably expected to remain constant and stable for the foreseeable future. The long-term picture for biomedical and behavioral research support remains unclear since this Administration will undoubtedly continue to seek areas where further cuts in domestic, non-entitlement programs can be made. As evidence of the continuing assault that can be expected, President Reagan recently proposed an across-the-board funding reduction of 12% for all such programs--only weeks after billions of dollars were cut through reconciliation. Even such short-term indicators as the appropriations level for the fiscal year that begins on October 1 are not yet clear. Although committees in both houses of Congress have made preliminary decisions about FY1982 appropriations levels for research and research training (see table below), it is highly unlikely that an appropriations bill can be approved and signed by the President before October 1. Therefore, the House and Senate have prepared separate versions of short-term "continuing resolutions" to provide funding for these programs in the hiatus between appropriations bills.

(in millions of dollars)

	Current FY1981 Appropriation	President's '82 Request	Senate Subcommittee's '82 Recommendation	House Committee's '82 Recommendation
Total NIH	3,569	3,762	3,818	3,835
NIH Training	176	134	164	164
ADAMHA Training	21	13	18	18
ADAMHA Research	210	214	188	214

To make matters even more uncertain, several additional glitches could occur within the next few weeks to further threaten biomedical and behavioral research funding: 1) conservative Members of Congress could launch an effort during consideration of a continuing resolution to lower funding to the levels advocated by the Administration; 2) the President could veto appropriations bills he believes to be excessive; 3) the Labor-Health and Human Services appropriations bill could be held hostage once again to controversy over abortion or busing language; or 4) the President could attain the authority to impound funds.

1981 FALL MEETINGS—NOVEMBER 1-2—WASHINGTON, D.C.

The six small business set-aside bills presently being considered by Congress have also recently captured the attention of the scientific community. These proposals would require Federal agencies with research and development budgets of over \$100 million to earmark a certain percentage of their budgets for allocation to small businesses. Although the percentages mandated in the bills range from 1% to 15%, all of the proposals violate the long-standing concept that biomedical and behavioral research support is based on scientific merit. The Senate small business set-aside bill (S. 881) was recently reported out of the Innovation and Technology Subcommittee after amendments were made to omit in-house research from the base used in calculating the set-aside and to phase in the bill's 1% set-aside figure over a period of three years for agencies, such as NIH, with extramural budgets over \$2 billion. The Senate bill is now supported by the Administration and has 85 co-sponsors. The House small business set-aside bills, which were recently the subject of a hearing by the House Small Business Subcommittee on General Oversight, are similarly garnering widespread support.

The use of animals for research will be the topic of a hearing scheduled by the House Subcommittee on Science, Research, and Technology for October 13-14. The hearing will focus, in part, on several recently introduced legislative proposals that advocate the development of alternatives to in vivo research methods currently employed. The proposal that appears to have the most widespread support is H.R. 556, "The Research Modernization Act," which would create within NIH a "National Center for Alternative Research." In addition, H.R. 556 would require that Federal research agencies expend 30% of their appropriated research funds for the development of alternative, in vitro testing methods.

Additional information about NIH and ADAMHA appropriations, the small business set-aside bills, and the animal research legislation may be obtained from the AAMC.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION IS EXPLORING EXAMINATIONS. In September, a committee of the ACGME presented four consensus statements on eligibility standards for entry into graduate medical education to the Council. These are being widely disseminated for comment (see AAMC Weekly Activities Report of September 24, 1981). The ACGME plans to establish final policy on this matter in the near future. Therefore, it is important that members of the academic community submit their views as soon as possible.

The committee report recommends that graduates of schools accredited by the Liaison Committee on Medical Education (LCME) continue to be eligible to enter accredited graduate programs without fulfilling any additional requirements. This is a statement against requiring passage of an examination such as the proposed FLEX I exam before entry into the first residency year.

For graduates of non-LCME accredited schools (whether aliens or U.S. citizens) the consensus statements set forth three requirements:

- Passage of an English language proficiency examination
- Passage of an examination to evaluate cognitive skills. The Visa Qualifying Examination is designated as an appropriate instrument.
- Assessment of clinical skills and professional qualifications by the faculty of the first year program with a report on their having acquired essential clinical skills required before a permanent certificate is awarded which would permit FMG residents to continue into the second graduate year

The intent to require a more rigorous cognitive exam than the one used by the Educational Commission for Foreign Medical Graduates (ECFMG) would eliminate the dual standard currently in effect for U.S. citizens and alien foreign medical graduates. However, the reliability of evaluation of essential clinical skills and professional qualifications by a program faculty with an interest in continuing a resident in their program is open to question. The Association has recommended that these skills be assessed prior to entry by direct observation in prepared test centers (see Summer, 1981 CAS Brief).

Faculty members and academic societies should direct their comments to John Gienapp, Ph.D.; Secretary, ACGME; 535 North Dearborn Street; Chicago, Illinois 60610 with copies to August G. Swanson, M.D.; Director, Department of Academic Affairs; AAMC.

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COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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The CAS Brief is prepared by the staff of the AAMC Council of Academic Societies and is distributed through the auspices of your member society.

PRESIDENT REAGAN SUBMITS FY1983 BUDGET REQUEST TO CONGRESS. As expected, President Reagan's budget for the fiscal year beginning in October 1982 calls for further cuts in social programs, increases in defense spending, and no change in the tax cut plan adopted last year. Early Congressional response reflects serious concern over the unprecedented \$91.5 billion deficit, and there has been considerable debate already about possible alternatives to the Administration budget.

Biomedical and behavioral research support would decline further under the new budget request. Despite public proclamations by both the President and Secretary Schweicker that the NIH budget will continue to grow, the \$101 million boost requested for that agency would provide only a 3% increase or well below what would be needed to keep pace with inflation. Especially troublesome are the projected decreases in the number of new and competing grants that could be funded. In FY1981, 5109 new competing projects were funded, and the 1982 continuing resolution will fund approximately 4,740 new and competing awards. The President's FY1983 request would provide funding for only 4,100 such awards which would mean a 20% drop in a two-year period of the principal source of funding for individual investigators. In an effort to keep the number of new and competing grants from falling even further, the Administration plans to reimburse only 90 percent of the negotiated indirect costs associated with all research grants. The number of research trainees supported by NIH would also continue to decline from 10,700 in 1981 and 9,700 in 1982 to only 8,915 in 1983. The Administration plans to continue the policy established for this fiscal year that permits payment of institutional allowances for training grants at approximately 50% of the level paid in 1981.

Funding for NIMH research is increased in the FY1983 budget but some of the increase is due to the folding-in of funding for services research. Thus, the total amount of money requested for biomedical and behavioral research supported by NIMH is \$144 million--only slightly above the comparable 1981 level of \$143 million. The number of new and competing grant awards that could be made in FY1983 with funding at this level would be 257 compared to 228 in FY1981 and 139 in FY1982. Research training sponsored by NIMH continues to decline to \$14 million. Only 803 trainees could be supported by this amount compared to 1264 in FY1981 and 945 in FY1982.

Expenditures for Medicaid and Medicare are slated for reductions of approximately \$5 billion in the President's budget. Several approaches are recommended for reducing Medicaid costs including 1) requiring recipients to pay a nominal fee (\$1-\$2) for each visit or day for services; 2) lowering Federal matching payments to states for optimal services to the categorically eligible and all services for the medically needy by three percent; and 3) allowing states to require children of Medicaid patients in long-term care facilities to contribute to the cost of their parents' care. Among the many changes proposed to reduce Medicare expenditures are 1) disallowing for reimbursement two percent of all Medicare hospital costs;

1982 FALL MEETINGS—NOVEMBER 7-8—WASHINGTON, D.C.

2) reducing reimbursement for in-patient radiology and pathology services from 100 to 80 percent of reasonable charges; and 3) requiring employers to offer employees age 65 to 69 continued private health benefits and making Medicare the secondary payer to these plans.

Financial aid for medical students would be severely curtailed by the Administration's budget. The Health Professions Student Loan program and the Exceptional Financial Need program have both been slated for no new funding. In addition, the Administration has proposed that graduate and professional students become ineligible for Guaranteed Student Loans--the major source of aid to medical students--as of April 1, 1982.

NEW ANIMAL RESEARCH BILL EXPECTED SHORTLY. The House Subcommittee on Science Research and Technology is reportedly nearing completion of a new animal research bill based in part upon hearings held last fall on this topic. The Subcommittee staff recently circulated a draft bill that included provisions to 1) authorize grants for the development of non-animal testing methods, 2) require that all research facilities obtain certification within three years from the American Association for Accreditation of Laboratory Animal Care (AAALAC), and 3) permit veterinarian and lay members of animal research committees veto power over inspection reports and reviews of research protocols. The AAMC and its member CAS societies have been extremely active in responding to these proposals. It is expected that soon after the new bill is introduced, the subcommittee will schedule a hearing followed quickly by a mark up session.

AAMC TO EXAMINE ETHICS ISSUES. At its January meeting, the AAMC Executive Council approved a recommendation by the CAS Administrative Board that the Association establish an ad hoc committee to address the multiple and complex issues surrounding research fraud and misconduct. The group will be asked not only to focus on the role of universities and academic societies in promoting high ethical standards but also to examine judicious and efficient mechanisms for responding to instances of misconduct. Dr. Julius Krevans, Dean of the University of California, San Francisco School of Medicine, will chair the ad hoc committee which will hold its first meeting in April.

CAS HOLDS INTERIM MEETING. The Council of Academic Societies held a highly successful interim meeting in January on "Biomedical Research: A Partnership Between the Federal Government and the Academic Medical Center." Plenary speakers--Dr. Bernadine Bulkley, Associate Professor of Medicine at Johns Hopkins; Mr. John Inglehart, special correspondent of The New England Journal of Medicine; and Dr. Edward Brandt, Assistant Secretary for Health--discussed the partnership from the vantage points of the research community, the public, and the Federal government respectively. The major portion of the meeting was devoted to small group discussions where CAS representatives had the opportunity to interact with 40 Congressional staffers and Executive branch officials. Participants felt that the meeting provided an excellent chance for informal dialogue between representatives of the research community and policy makers in Washington about the nature, productivity and future of the biomedical research enterprise. Among the many outcomes of the meeting was the recognition on the part of CAS representatives that this type of dialogue must continue to be fostered if the research enterprise is to continue in a strong and effective manner. CAS representatives or officers desiring assistance in making contacts with Congressional or Executive branch officials should contact Dr. Seymour Perry's office at AAMC (202-828-0480).

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
(202) 828-0400

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NIH AUTHORIZATION LEGISLATION. House: H.R. 6247 introduced by Cong. Waxman, Chairman of the House Subcommittee on Health and the Environment was recently marked up. The following provisions are of particular interest: 1) an interagency coordinating committee for kidney, urological, and skin diseases; 2) research and training centers for endocrine and metabolic disorders; 3) research centers for digestive, kidney, and urological diseases; 4) a program of 25 "Centers for Research and Demonstration of Health Promotion and Disease Prevention" with authorizations of \$10, \$20 and \$25 million for the next three fiscal years; 5) research in spinal cord regeneration with authorizations of \$16, \$18 and \$20 million for FY 83-85 and an Interagency Committee on Spinal Cord Injury; 6) statutory language for peer review of intramural research and extramural contracts; 7) transfer of NIOSH and NCHSR to NIH; 8) authorization levels 10% above the Administration request. Senate: S. 2311 introduced by Senator Hatch has been marked up and includes provisions to: 1) retain the NCI budget bypass; 2) require advisory boards to be advised of any investigations for fraud, etc. concerning recipients of grants or contracts; 3) establish a National Kidney and Urologic Disease Advisory Board; 4) extend the President's Commission on Ethics to the end of FY 84; 5) require establishment of appeal procedures on grants and contracts; 6) establish a President's Council for the Health Services to develop by the end of 1984 a "National Health Sciences Plan" to set long-term priorities for "health sciences" research; 7) establish authorization levels that are 3% above the Administration's budget request.

ANIMAL RESEARCH. Congressman Doug Walgren (D-PA), Chairman of the House Subcommittee on Science Research and Technology, recently introduced a new animal research bill entitled, "Humane Care and Development of Substitutes for Animal Research Act." The new bill (H.R. 6245) would provide authority (\$10 million in 1983, \$15 million in 1984, \$20 million in 1985) for awarding research grants and contracts for the development of non-animal testing methods. Research protocols involving animals would require review and approval by institutional animal research committees. The bill also requires all research facilities to obtain certification from the American Association for the Accreditation of Laboratory Animal Care (AAALAC). Markup of the animal research bill is expected shortly.

SMALL BUSINESS SET-ASIDE. The small business set-aside bill (H.R. 4326) is awaiting a rule from the House Rules Committee--the final step in the legislative process before a bill can be voted on by the House of Representatives. If the bill receives a rule and is approved in any form by the House, that version will go to conference with the unanimously-passed Senate bill. The AAMC and many other national organizations continue to urge defeat of H.R. 4326 in its entirety. The bill would require the major science agencies to set-aside as much as three percent (approximately \$1.4 billion) of their R&D funds as an entitlement program restricted to small businesses. The funds awarded through these programs would be over and above those awarded through normal grant and contract procedures.

**1982 AAMC ANNUAL MEETING—NOVEMBER 6-11—WASHINGTON, D.C.
(CAS FALL MEETINGS—NOVEMBER 7-8)**

SHIFTS IN MEDICAL SCHOOL FORMS OF FINANCIAL SUPPORT. During the past 20 years the revenues supporting medical school programs have increased by a factor of 4.7 in constant dollars. More striking is the shift in the sources of support.

<u>SOURCES OF RESTRICTED REVENUES FOR SPONSORED PROGRAMS</u>				<u>SOURCES OF UNRESTRICTED REVENUES FOR GENERAL OPERATIONS</u>			
	<u>1960</u>	<u>1970</u>	<u>1979</u>		<u>1960</u>	<u>1970</u>	<u>1979</u>
Total Dollars (millions)	222	933	2,386	Total Dollars (millions)	214	780	3,316
Research	76%	52%	53%	State & Local Governments	32%	37%	35%
Training	22%	24%	23%	Indirect Costs	9%	13%	10%
Services	3%	25%	25%	Medical Service Plans	6%	15%	20%
				Tuition & Fees	13%	8%	9%
				Endowment & Gifts	13%	7%	4%
				Other	27%	20%	22%

REVENUES FROM MEDICAL SERVICES
(millions of dollars)

	<u>1960</u>	<u>1970</u>	<u>1979</u>
Faculty Practice Plans	13	115	670
Hospitals and Clinics	22	58	380
Medical Service Contracts	5	172	448
TOTAL	40 (17%)*	345 (34%)	1,498 (40%)

*Percent of Unrestricted Revenue for General Operations

The proportion of revenues from state and local governments has risen by two percent while the proportion from tuition and endowment income has fallen. Research and research training remain the major sources of restricted revenues, but revenue from restricted medical service programs has increased substantially.

Support for medical school programs from income generated by faculties' provision of medical services has proportionally increased more than any other source. In 1960, 17% of revenues for general operations was generated from faculty practice. By 1979 this had risen to 40%. It is expected that the 1980 figures will be at least as high and probably higher. These shifts in sources of revenue to support medical education are away from federal sources and toward state and local sources, but federal policies for programs such as Medicare-Medicaid and for research and research training remain vital issues for academic medical centers.

ECFMG PLANNING A SINGLE EXAM FOR ALL FMGs. The Educational Commission for Foreign Medical Graduates (ECFMG) has responded to the concerns of the CAS and AAMC about the need to improve the examination standards for certification of FMGs for graduate medical education. Anticipating that the Accreditation Council for Graduate Medical Education (ACGME) will change the eligibility requirements for graduates of schools not accredited by the Liaison Committee on Medical Education, the ECFMG has asked the National Board of Medical Examiners (NBME) to develop an examination equivalent to NBME Parts I and II to replace the present ECFMG examination.

When implemented, alien and U.S. citizen foreign medical graduates will be required to pass the examination. Presently, aliens must pass the Visa Qualifying Examination, which is considered by the Secretary of HHS to be equivalent to Parts I and II, while U.S. citizens must only pass the less rigorous ECFMG examination.

The ACGME is still exploring how the non-cognitive skills and qualities of foreign medical graduates can be evaluated effectively. It can be anticipated that some form of non-cognitive evaluation will be required in addition to the new written examination.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

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ETHICAL STANDARDS IN RESEARCH. The Association's Executive Council has adopted the report of a committee chaired by Julius R. Krevans, M.D., chancellor of the University of California, San Francisco, on The Maintenance of High Ethical Standards in the Conduct of Research.

The report places great emphasis on the responsibilities faculties have to create a climate that promotes faithful attention to high ethical standards and recommends that faculties and their institutions encourage quality rather than quantity of research publications. The need for participants in multi-authored papers to have had a genuine role in the research and accept responsibility for the quality of the work reported is stressed.

The report also sets forth guidelines for faculties and institutions to consider when accusations of fraudulent research are made. These include how allegations should be reported and investigated and what actions should be considered when the allegations are either proven or disproven. Copies of the report are available from the Division of Biomedical Research, AAMC.

ESTABLISHMENT OF NEW NIH INSTITUTES. The House Energy and Commerce Committee has accepted an amendment to H.R. 6247, the House NIH reauthorization bill (see Spring, 1982 BRIEF) which would establish a separate institute for the study of arthritis, musculoskeletal and skin diseases. Such an amendment was not adopted as part of the Senate NIH authorization bill but Senator Barry Goldwater (R-Arizona) has introduced legislation (S. 1939) to establish a National Institute for Arthritis and Musculoskeletal Diseases. The bill is co-sponsored by 32 Senators. At Senate Labor and Human Resources Committee hearings on the legislation held July 20, NIH Director James Wyngaarden and several members of the academic community expressed concern regarding the fragmentation of the research effort which may result from the proliferation of additional disease-specific institutes. It was emphasized that the establishment of such institutes does not represent a logical scientific approach to research for the cure and treatment of these illnesses.

There is also considerable support for the establishment of a separate diabetes institute and proposals to establish additional institutes in such areas as communicative disorders, pulmonary diseases and kidney diseases have gained momentum in recent months. The AAMC has expressed its support for a proposal by Representatives Edward Madigan (R-Illinois) and Richard Shelby (D-Alabama) that an Institute of Medicine study of the NIH organizational structure be conducted and that standards against which to justify the establishment of new institutes be identified prior to the establishment of any additional institutes.

**1982 AAMC ANNUAL MEETING—NOVEMBER 6-11—WASHINGTON, D.C.
(CAS FALL MEETINGS—NOVEMBER 7-8)**

PASSAGE OF SMALL BUSINESS SET-ASIDE LEGISLATION. On June 23, the House of Representatives passed by an overwhelming margin H.R. 4326, "The Small Business Innovation Development Act." The legislation requires federal agencies with research and development budgets in excess of \$100 million per year to set aside 1.25% of their budgets (phased in over four years) for allocation to small businesses (see Spring, 1982 BRIEF). Amendments offered by Congressmen Henry Waxman (D-CA) and George O'Brien (R-IL) to exempt the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration from the provisions of the legislation were not adopted. On June 29, the Senate agreed to the House version of the legislation. (The Senate had already passed similar legislation in December of 1981.) In view of the Administration's support for the original Senate bill, a presidential veto is highly unlikely.

GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN PROJECT BOOKLET. The General Professional Education of the Physician project, chaired by Steven Muller, president of the Johns Hopkins University, has generated a booklet that has been sent to all the representatives and officers of member societies. The purpose is to focus discussion on some assumptions and questions about medical education and college preparation for medicine. The booklet describes the charges to three working groups that have been appointed to consider the essential knowledge; fundamental skills; and personal qualities, values and attitudes that should comprise the general professional education of the physician. Professorial society presidents have particularly been asked to organize discussions of the charges by their members and other societies for their discipline.

One of the major concerns that has emerged thus far in the project is the huge amount of information that students are expected to assimilate during medical school. Approaches that faculties might use to identify essential knowledge for students' general professional education as opposed to knowledge to be gained later in their specialized graduate medical education are being sought.

Copies of the booklet are available. Contact Mary H. Littlemeyer, Project Coordinator at (202) 828-0500.

1982 AAMC ANNUAL MEETING. The AAMC Annual Meeting will be held at the Washington Hilton Hotel in Washington, D.C. on November 6-11, 1982. The theme of this year's meeting is "Academic Values in a Changing Environment." Speakers at the November 8 plenary session will include Treasury Secretary Donald Regan who will describe the changing economic environment and former HEW Secretary Elliot Richardson who will discuss the maintenance of social values in a changing world. On the morning of November 9, Hanna Gray, president of the University of Chicago, will discuss the preservation of academic values in the university and Sherman Mellinkoff, dean of the UCLA School of Medicine, will give the Alan Gregg lecture on the preservation of academic values in the medical school.

On the afternoon of November 9, a special session on geriatrics and medical education will be held. Speakers will include Dr. Joseph E. Johnson, chairman of the department of medicine at Bowman Gray School of Medicine, who will discuss the outcome of the AAMC Regional Institutes on Geriatrics in Medical Education which he chaired.

Activities of the Council of Academic Societies (November 7-8) will include a joint session with the AAMC Organization of Student Representatives focussing on the General Professional Education of the Physician Project.

BROCHURE ON DIRECT AND INDIRECT COSTS OF RESEARCH. An overview of the costs associated with research is provided in a booklet entitled, "Direct and Indirect Costs of Research at Colleges and Universities" published by the American Council on Education. Copies may be obtained from the Division of Governmental Relations, American Council on Education, One Dupont Circle, Suite 824, Washington, D.C. 20036.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES • 1 DUPONT CIRCLE NW • WASHINGTON DC
(202) 828-0400 FALL 1982 VOL. 8, NO. 1

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NIH AND ADAMHA FUNDING. The Congress succeeded in passing only 2 of the 13 major appropriations bills prior to its adjournment for the November elections. Consequently, most government agencies are now operating under a continuing resolution due to expire on December 17. The research, research training, and clinical training programs of the Alcohol, Drug Abuse, and Mental Health Administration are funded at FY1982 levels (without an inflationary increase). With regard to the National Institutes of Health, the Senate version of the continuing resolution specifies that the NIH is to be funded at a level of \$205 million over the Administration's budget request to permit maintenance of the 1982 level of effort. However, the report language accompanying the joint resolution is less specific and there have been indications that the Office of Management and Budget (OMB) may ignore the obvious intent of the Senate and allocate funds to NIH at the FY1982 level (without an inflationary increase).

With regard to the appropriations bills, the full House Appropriations Committee has passed the FY1983 Labor/HHS/Education spending bill. For the NIH, slightly more than \$4 billion is allotted such that 4,900 competing grants could be funded. 10,000 research trainees could be supported by NIH with the \$170.3 million allotted for research training. For ADAMHA, \$233.2 million is allocated for research, \$16.4 million for research training, and \$18.0 million for NIMH clinical training. Report language accompanying the bill specifically restores the Administration's proposed 10% reduction in indirect costs associated with research grants. The Senate Labor/HHS/Education Appropriations Subcommittee has not yet marked up its bill.

OUTLOOK FOR THE POST-ELECTION SESSION. The Congress will return in late November for a post-election lame duck session. Although the President requested the session so that Congress might continue working on FY1983 appropriations legislation, it is likely that other issues will be considered including legislation to limit the use of animals in research and the establishment of a separate arthritis institute (see Spring and Summer issues of the CAS Brief). NIH reauthorization legislation, including a provision to establish a separate arthritis institute, has passed in the House. However, the Senate companion bill has yet to be considered on the Senate floor. In the event that the Senate bill is not passed and conferenced with the House version during the lame duck session, the programs which the legislation authorizes (including the National Cancer Institute; National Heart, Lung and Blood Institute; and the National Research Service Awards program) would continue operating under the broad authority provided in Section 301 of the Public Health Service Act.

CHANGES IN THE MEDICARE PROGRAM. The Health Care Financing Administration (HCFA) has published regulations to implement changes in the Medicare program mandated by Congressional passage of the Tax Equity and Fiscal Responsibility Act. Embodied in the regulations are proposals which would limit reimbursement of hospital-based physicians--particularly for pathology, anesthesiology, and radiology services. The regulations also include a proposal to reduce by 40% the allowable fees for many services provided in hospital outpatient departments. Comments on these portions of the new regulations will be accepted by HCFA until October 30. For additional information, contact the AAMC Department of Teaching Hospitals at 202-828-0490.

**1982 AAMC ANNUAL MEETING—NOVEMBER 6-11—WASHINGTON, D.C.
(CAS FALL MEETINGS—NOVEMBER 7-8)**

PRESIDENT'S COMMISSION ON ETHICAL PROBLEMS REPORT. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research will release a report in late October entitled, "Making Health Care Decisions." The focus of the report is on improving patients' participation in making informed decisions about their medical care. The Commission believes that the narrow legal process of informed consent does not ensure that patients have sufficient information and knowledge to participate in decisions regarding their own care. Rather than recommending legal reforms, the report places its major emphasis on improving health professionals' ability and willingness to provide information to patients and to assist them in understanding the implications of the decisions they are making. In the Commission's view, this will require that the development of this ability be given special attention in the education of health professionals. Copies of the report can be obtained from the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402; price: \$6.00

POTENTIAL INSUFFICIENCY OF GRADUATE MEDICAL EDUCATION POSITIONS. A potential insufficiency of graduate medical education positions was the focus of a combined meeting of the Administrative Boards of the Council of Academic Societies, Council of Teaching Hospitals, and the Organization of Student Representatives in September. During the past 15 years there has been a 107 percent increase in the number of medical school graduates and only a 37 percent increase in entry level graduate medical education positions. In 1966 there were 1.78 first year positions available for each U.S. graduate. In 1981 there were only 1.18 positions available and in 1982 this dropped to 1.12. In 1982 the number of positions offered in the National Resident Matching Program was fewer than the number offered in 1981. Such a decrease has not occurred since freestanding, rotating internships were eliminated in 1975. Nearly 2,200 of the 18,293 positions offered in the 1982 match were in programs that tend not to attract any U.S. graduates. If these are deducted from the total pool, the ratio of positions to graduates in 1982 was 0.99.

Discussion of the problem brought out that presently unattractive programs are unlikely to have the resources needed to improve their quality and that the increased stringency of application of accreditation standards by RRCs is also tending to decrease the number of programs and positions. Concerns were also voiced about the effect of the effort to control hospital costs on the ability of teaching hospitals to maintain a sufficiency of graduate medical education opportunities.

Graduate medical education is an essential phase in the education of physicians. The possibility of there not being sufficient resources to provide this phase for all graduates has serious portents and must be of concern to medical school and teaching hospital faculties and policymakers responsible for decisions that affect the support of graduate medical education.

Schools and Societies Participate in the GPEP Project. Medical schools and professorial societies have demonstrated a high level of interest in the AAMC General Professional Education of the Physician and College Preparation for Medicine project. Eighty-six medical schools and 19 professorial societies are organizing discussions on the Essential Knowledge; Fundamental Skills; and Personal Qualities, Values, and Attitudes that should comprise the education of physicians. The project's advisory panel has scheduled hearings in 1983 to provide an opportunity for institutions, societies, and individuals to present their views on the project. The hearings are scheduled for:

University of California, San Francisco - January 24

University of Texas, Houston - February 24

Northwestern University, Chicago - March 24

New York Academy of Medicine, New York - May 5

Details about the hearings will be available from Mary H. Littlemeyer, Project Coordinator, after December 1, 1982.

COUNCIL OF ACADEMIC SOCIETIES BRIEF

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FUTURE AAMC ACTIVITIES IN GERIATRICS AND MEDICAL EDUCATION. In 1982, the AAMC convened four Regional Institutes on Geriatric Medical Education as a first step in coping with the challenge presented by a rapidly increasing elderly population. A document entitled, "Undergraduate Medical Education Preparation for Improved Geriatric Care--A Guideline for Curriculum Assessment," has been prepared by the Association's steering committee, consultants and staff and approved by the AAMC Executive Council. It will be published as a supplement to the Journal of Medical Education in the spring and then broadly disseminated. It is not intended as a model curricula but offers guidelines to faculty on integrating information on geriatrics and gerontology into curricular concepts and materials.

The AAMC has identified two ways to assist in implementing the recommendations embodied in the document: 1) Encourage and assist professional organizations to include in the programs of their annual meetings discussion of the document or topics related to gerontology and geriatric medicine; 2) Act as a clearinghouse to arrange "visiting professorships" for recognized leaders in gerontology and geriatric medicine to visit medical schools and teaching hospitals. The AAMC will publicize the service and match requests from individual institutions with an appropriate expert. For further information, contact Dr. John Sherman, Vice President, AAMC at 202-828-0470.

PROPOSED SLIDING SCALE FOR GRANT AWARDS FOR BIOMEDICAL RESEARCH. As a result of increased competition for fewer available research dollars, a number of proposals have surfaced in an effort to stretch existing Federal resources. In a letter to Science (February 1982), Elliot S. Vesell, Dept. of Pharmacology, Pennsylvania State University and H. George Mandel, Dept. of Pharmacology, George Washington University proposed that NIH grants be awarded on a sliding scale basis in order to fund a larger number of research proposals. Viewed as a temporary measure, this would involve partial funding based on a formula related to the priority scores assigned by study sections--providing 100% funding on proposals with "top" priority scores and partial funding on others with "respectable" scores. A number of concerns and questions have been raised: 1) Study sections have already been recommending reductions in funding when it was felt that a project could be carried out with fewer resources; 2) Will those who receive partial funding be expected to make up the difference and if so, how? If this could be done temporarily, why not permanently? 3) If the difference cannot be made up, is the presumption that the same project can be completed for less money or is it expected that the project will be significantly modified? If the former is true, could it not be concluded that projects have been overfunded and that there is room to cut back and still achieve a comparable outcome? If the latter is the case, how would revisions be made and would another review cycle be required? 4) How would this proposal affect the peer review mechanism now in place--would it still be necessary? The AAMC is concerned about preserving the peer review system and the criterion of scientific excellence as the basis for funding. It is also concerned about the illusion created by this proposal that we are able to cut back on costs and maintain the scope and quality of research projects conducted. It is likely that this proposal and others like it will be gaining visibility in the coming months and that member societies of the CAS will be encouraged to take a position.

The Association has been invited to submit a nomination for the Albert Lasker Medical Research Award. Readers of the Brief are urged to send to Gus Swanson the names of biomedical scientists for either the basic or clinical research award. Please include a brief summary of their scientific contributions. The deadline for receipt is March 28, 1983.

OUTLOOK FOR THE 98TH CONGRESS. Congressional action may have major consequences for academic medical centers. CAS societies should be prepared to exert significant effort to forestall detrimental legislation in the following areas:

- FY 1984 Budget Proposal--Preliminary figures from the Administration include only a 1.8% increase for NIH, supporting approximately 3,700 new and competing grants (compared with 4,900 this year) and 9,100 research trainees (compared with 10,000 this year). This includes a recommended 10% reduction in indirect cost reimbursement. It is generally agreed that Congress will reject a plan that so significantly reduces the number of grants and trainees supported. With respect to ADAMHA funding--clinical training would be totally eliminated; research programs would be increased substantially, and research training would receive a modest increase. The Veterans Administration research program would be increased slightly.
- Animal Research Legislation--Senator Robert Dole (R-KS) and Representative Doug Walgren (D-PA) are expected to introduce legislation regarding the use of animals in research in the near future. Senator Dole is expected to propose amending the Animal Welfare Act to: require that the Animal, Plant, and the Health Inspection Service (an agency of the Dept. of Agriculture) upgrade its standards, that APHIS inspectors examine research methodology, and that institutional animal care committees be established. (This differs markedly from Dole's proposal last session.) Representative Walgren is expected to introduce legislation similar to that which he proposed during the last session which would require that facilities meet accreditation standards set by an outside agency (presumably the American Association for the Accreditation of Laboratory Animal Care), that institutional animal studies committees be maintained to conduct periodic inspections, and that special attention be given to the development of research methods which use "fewer or no animals."
- NIH Authorizing Legislation--The primary purpose of this legislation is to renew expiring NIH authorities including those for the National Cancer Institute; National Heart, Lung and Blood Institute; the National Research Service Awards Program, and part of the National Library of Medicine. (Other NIH institutes exist under the open-ended authority provided in Section 301 of the Public Health Service Act.) Representative Waxman's (D-CA) bill, which passed the House in the last session, included a variety of disease-specific provisions, e.g. establishment of a separate arthritis institute. On the Senate side, Senator Orrin Hatch (R-UT) introduced a bill which was neither as specific nor as broad. A provision to establish a separate arthritis institute was included. The bill, however, did not reach the Senate floor and, thus, no legislation was enacted into law. Both Senator Hatch and Representative Waxman are expected to introduce legislation in the very near future.
- Other issues expected to be considered in this session are prospective pricing proposals for hospital services provided to Medicare beneficiaries and controversial legislation to restrict fetal research which had passed the House as an amendment to the NIH reauthorizing legislation, but was not considered by the Senate during the last session.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES. The Educational Commission for Foreign Medical Graduates will introduce a new examination for graduates of foreign medical schools who seek to be certified by the Commission. The two day Foreign Medical Graduate Examination in the Medical Sciences will consist of a one day examination in the basic sciences and one day in the clinical sciences. Each section will have to be passed for a candidate to qualify for certification. The basic science section may be taken after two years of attendance at a school listed in the WHO Directory. The new FMG Examination in the Medical Sciences will be the only examination and will be used by the ECFMG for certification and by the State Department for visa qualification. The first administration will be in July of 1984.

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