association of american medical colleges

FUTURE CHALLENGES

FOR

THE COUNCIL OF ACADEMIC SOCIETIES

A Discussion Paper

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DRAFT

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The Council of Academic Societies was formed in 1966 as the mechanism for faculty representation in the governance of the AAMC. At the first meeting it was resolved that "...the Council should address itself to problems that were general enough to concern many, not so global as to present the temptation to allow escape into dialectic, well enough circumscribed so that they were solvable and important enough so that the answer when arrived at would be worth having."

The challenge of identifying such issues for debate and action has continued unabated since, with policies formulated and national consensus developed on a wide range of issues in medical education, research and patient care. But there is no surcease; the challenges facing the medical schools today are as great as they have ever been.

Thus, as we approach the 20th year of the tripartite organization of the AAMC, a consensus emerged that it would be worthwhile for each of the three Councils to review its organization, membership and activities and to undertake a long-range effort to identify those issues which from its perspective represented the major challenges of the next five years.

The Council of Academic Societies devoted its 1984 Spring meeting to the identification of some of these issues and this paper continues that effort to delineate the challenges and suggest the role of the CAS and the AAMC in helping to meet them. This draft document identifies issues and suggests areas for CAS involvement but deliberately makes no attempt to establish priorities or specify an action calendar. It is intended to serve as a

discussion paper to ensure that the challenges facing the faculties are identified as comprehensively as possible. The Council should view this wide-ranging paper as a potential set of agenda items for future CAS deliberation and a common base from which the next generation of discussions will focus on deciding which of these many challenges facing the faculties are suitable for CAS action and what the priority among those key issues should be.

Despite dramatic changes in the environment of the medical school, the three traditional missions of the faculty collectively remain unchanged. These are the education of predoctoral and postdoctoral students and professionals in medicine and the medical sciences, the generation of new knowledge and insights in the biomedical and behavioral sciences, and the provision of the highest quality patient care in our academic medical centers.

Challenges in Education

Background

Medical school faculties are responsible for the education and training of over 140,000 students in medicine and the biomedical sciences (Table 1).

Table 1

Medical Students	66,484
Residents	50,381
Graduate Students in Basic Science	16,701
Clinical Fellows	7,133
Total	140,689

There is great variation in the student mix among institutions. At one institution the combined total of graduate students and residents is 2.6 times greater than the number of medical students. At another, the number of medical students is greater by a factor of 2.7.

The diversity in numbers and types of students among academic medical institutions reflects the variation among them in their degree of concentration on the three major missions common to all--education, research, and service. However, every medical school faculty member would concede that education is the singular mission that characterizes academic medicine. Biomedical research is done in organizations other than medical schools and medical services are principally provided by non-academic physicians and hospitals. The education of young men and women who will be future practicing physicians, clinical investigators, and biomedical scientists is a responsibility unique to the academy. It follows that a principal concern of the Council of Academic Societies should be the continual improvement of biomedical education.

During the past three decades the educational responsibilities of medical school faculties have grown and become more complex. Medical school faculty increasingly participate in teaching students from the other health professions as well as their own medical and graduate students, and clinical faculty additionally teach both a growing cadre of residents and an expanding program of continuing medical education for practicing physicians. This heterogeneous "student body" must be addressed at different levels of sophistication, and the demands on faculty time and energy have correspondingly increased. At the same time the amount of information to be transmitted has grown exponentially, and the technological aspects of biomedical science have become more complicated.

One major approach to handling this educational challenge has been to increase the total time students spend in their programs. Although medical school remains a four year program, the number of weeks of required attendance

has increased, and the number of subjects tackled simultaneously has mounted. Residency programs are being lengthened as is postdoctoral training for biomedical scientists. It seems apparent there must be a practical limit to this strategy.

The Issues

The commitment to education by most medical school faculty members is influenced by how much this responsibility interdigitates with their research and service activities. Residents and clinical fellows who assist in patient care and research, and graduate and postdoctoral students who collaborate with faculty members in research receive personal time and attention from faculty members. Contact with medical students is considered important, but faculty members most often confine their contribution to medical student education to simply transmitting their specialized store of information to them. There is a universal perception that educational activities that do not contribute to, or detract from, productivity in research or patient care are likely to hinder recognition and advancement. Engagement with medical student education is thus the third priority for most of our faculties.

The increase in the number of students of all categories, although accompanied by an even greater increase in the number of faculty members, has diminished the personal relationship between students and faculty. This holds true not only for medical students whose number has doubled in the past two decades but also for graduate students, residents, and fellows. In many institutions chairmen and senior faculty do not have sufficient time to get to know the cadre of students for whom they have ultimate responsibility.

In the foreseeable future it is unlikely that faculties' involvement in research and patient care will change. Indeed these missions are apt to

make greater demands on the energy and time that is available. It is also unlikely that the number of students will decrease significantly, and the mix may become more complex as specialization increases in both basic science and clinical disciplines. If the education of all students for whom faculties have responsibility is to be improved, a multifaceted approach that involves restructuring the organization and the methods for accomplishing the educational mission of medical school faculties must be undertaken.

Strategies

I. Accreditation, Licensing and Specialty Certification

In the United States the faculties of institutions of higher education are privileged to determine the content of students' education and the methods of their instruction within broad guidelines set forth by accrediting agencies. For medical school faculties these agencies include the Liaison Committee for Medical Education for medical student education and the Accreditation Council for Graduate Medical Education for resident education. To a significant degree the faculties' decisions about educational programs for medical students and residents are also influenced by professional licensing policies in the states, national licensing examinations used by states, and the policies and examinations of medical specialty certifying boards.

Thus, while faculties have the ultimate responsibility for accomplishing the educational mission of their institutions, there are practical limits to educational experimentation in medical student education that are imposed by external authorities. Accrediting bodies tend to perpetuate conventional educational approaches and may inhibit improving the education of the students for which medical school faculties are responsible.

- o Are CAS representatives and their societies sufficiently knowledgeable about the policies of accrediting, licensing, and certifying agencies?
- o Are there specific policies at present in force that need to be altered if the education of all types of students for which medical school faculties are responsible is to be improved?
- o *Should the CAS become involved in examining the effect on medical education of the policies of accrediting, licensing, and certifying authorities?* 1

II. Specialization and Fragmentation

Specialization in both basic and clinical sciences is increasing with the growth of knowledge and the complexity of research, diagnostic, and therapeutic technologies. Specialization inevitably leads to fragmentation as individuals with common interests draw together to share their experience and accomplish a common goal. At the national level this is evident in an increasing number of societies and associations and at the institutional level in multiple administrative units. The ability of faculties to provide a broad-based and integrated biomedical education is complicated by this trend towards specialization.

- o Is increasing specialization in the biomedical sciences impairing students' education?
- o *Should the CAS provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences?* 2

III. Intrainstitutional Competition

Within the institutions there are competitive pressures among specialties that may or may not accrue to the benefit of students' education. Some examples of these are: a) Departments and divisions competing for an increased share of time in medical students' curricula in order to expose students to a discipline or specialty in hopes of recruiting them, or to enhance their f.t.e. faculty involvement with medical student education; b) Clinical departments and divisions competing for bed space or for preferential control of procedures and facilities to enhance their service and/or research capabilities or to enlarge their educational programs for residents and fellows; c) Basic science departments competing for research space to augment their research and graduate student education programs.

- o Do these competitive pressures significantly detract from an institution's ability to meet its educational obligations to all of its students?
- o *Should CAS examine the effects of intrainstitutional competition on biomedical education?*

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IV. National Competition Among Disciplines and Specialties

At the national level, especially among clinical disciplines and specialties, there is competition for recognition and for students. This is evidenced by the proliferation of specialty certifying boards and subcertification of special competence by established boards. Competition for students contributed to the move by ophthalmology, neurosurgery, otolaryngology, and neurology to develop a separate matching program that selects medical students early in their senior year for entry into residency programs in their second postgraduate year.

- o *Should CAS play a more vigorous role in debates about the creation and recognition of new specialties and subspecialties?* 4
- o *Should CAS examine the effects on students' education of the competition by various disciplines and specialties to recruit them?* 5

V. Priority of Medical Student Education

The faculties of academic medical centers are involved in research and clinical service missions that demand a large measure of their attention and efforts. These missions compete for faculty time and energy with each other and with the educational mission. Because the revenues generated from successful competition for research grants and from patient care activities inure to the benefit of departments, institutions, and individuals, these activities have a high priority. Attention to education of graduate students and postdoctoral M.D.s who are participants in these activities with the faculty is relatively easy to integrate and justify. By contrast, the education of medical students is often viewed as an activity for which there is little financial support and less commitment of institutional resources.

- o Is an apparent lack of financial support for medical student education a deterrence to faculty involvement with this mission?
- o *Should the CAS undertake an examination of how medical student educational programs are supported?* 6

Individual faculty members' commitments to working with medical students will be conditioned by their perceptions of institutional priorities. These

priorities are conveyed by the attention and interest which deans and department chairmen devote to medical student education and their willingness to support and enhance the commitment of their faculty members to working with medical students. CAS members include societies of chairmen for essentially every discipline and specialty in academic medicine.

- *Should CAS work with department chairmen to increase the institutional priority for medical student education?* 7

Ultimately, all efforts to improve medical education depend upon the depth of commitment of individual faculty members to this mission. The planning and implementation of improved educational programs for all types of students requires both intra- and interdisciplinary discussions and debates. Faculty must work collegially as well as with deans and chairmen on educational issues, and a significant investment of time and energy by faculty is required to accomplish desired educational improvements.

- *Should CAS examine how faculty involvement in planning and implementing improvements in medical education can be enhanced?* 8

The General Professional Education of the Physician Project has identified the importance of focusing on the personal development of each student. To make the student the focus of education requires that faculty members devote time to working individually with medical students and that students assume personal responsibility for their own education. Working with students as active learners rather than passive recipients of information is labor-intensive and requires teaching skills which differ from those necessary to transmit specialized factual information in a lecture format.

Assistance in strengthening such interpersonal teaching skills may be useful to faculty as they seek to develop curricula which provide for more individual learning.

- *Should the CAS help member societies develop programs to assist faculty within their disciplines in augmenting teaching skills?*

Challenges in Research

Background

The past 20 years have witnessed an unparalleled explosion in our knowledge and understanding of fundamental processes in the biological sciences. Indeed, this can be characterized as the golden age of biology. The fruits of these discoveries, ever more readily applied to solving problems of human health and biomedical research, have contributed to improved survival and better quality of life for people afflicted with a broad range of diseases. Despite this opportunity there has been a slowing of growth in research funding. Federal research support to our medical schools in constant dollars grew through the early 1970s but has declined an annual average 4.4 percent over the last five years. Between 1961 and 1981, these funds declined from 31 percent to 22 percent of total financial support of medical schools. In constant dollars, federal support for research training through the NRSA Program declined from $159 million in FY72 to the 1972 equivalent of $76 million in FY83. While the number of

individual investigator (RO1) NIH grantees has been over 12,000 for the past five years, the percent of new P.I.s has been falling steadily. The 8.3 percent new grantees in 1982 was the lowest percentage since 1970. The number of clinical (M.D.) investigators also continues to decline from 32 percent of the new principal investigators in 1968 to 15 percent in 1982.

The Issues

Faculty members see the availability of research funds as the most urgent challenge to continuing their research mission. They want to identify effective ways to communicate to Congress the importance of an investment in basic research as vital to future progress in improving health and as substantively different from day to day expenditures on health care. They do not see any other sector of the economy as a major source of funds for such research, although they do see university-industry relationships as of importance in a limited and targeted number of areas.

Experience with this no growth era in research funding has led to concerns in a variety of areas. There is a desire to achieve an appropriate balance between funds devoted to disease-specific research and those devoted to interdisciplinary or more basic research; between funds expended on "safe" versus innovative or high risk research; between funds expended for investigator-initiated research versus programmatic research for funding; and between funds to support the direct versus the indirect costs of research.

There is concern that under increasing fiscal pressures the peer review process is becoming eroded or politicized, and that the peer review process engenders a sense of futility in reviewers and applicants alike when so much meritorious research cannot be funded. Discussion has arisen about the feasibility or desirability of identifying the most promising areas of research and establishing priorities for the next five years across disciplines.

There is concern that an attempt to even out arbitrary year-to-year fluctuations in the number of grants awarded has been twisted into an inflexible mandate that 5,000 grants must be funded yearly, regardless of whether this represents too high or too low a proportion of the NIH budget, and regardless of the actual number of meritorious research proposals submitted. Some means must be found to explain the desirability of long term stability in research funding and the opportunities for creative research which cannot be funded with the present budget limitations, while avoiding reliance on a single number or percent of grants. NIH must retain the flexibility to make funding decisions based on research opportunity and scientific merit.

Attracting the best minds to research and providing proper support of research training and early faculty development are high priority issues for faculty. There remains serious concern that the increased competition for limited research funds makes a career in research seem less attractive to young people and that high indebtness of medical students will serve as a further disincentive to consideration of a faculty career. While there is enthusiasm for new training programs such as the Physician Scientist Awards, faculty are aware that, especially in training clinical investigators, there is need for institutional training grants which can provide entree for those with no prior research experience. There is concern that policymakers must appreciate that such training programs will have a lower yield of career

researchers than those which select fellows with previous research experience. In the present job market placing young trainees in faculty positions and providing adequate support during the startup years has become more crucial, and faculty realize that special effort needs to be devoted to ensuring a continuous flow of young, talented people into the academic ranks. Support may also be needed for mid-career faculty to enable them to update research skills and remain competitive in an era of increasingly sophisticated research technology.

It seems doubly difficult that an environment already fiscally restricted should face increasing regulation as well, but specific directives are in effect or pending in regard to disposal of chemical and low level nuclear waste, to release of genetically engineered organisms in field trials, and in regard to the use of animals in research. The latter threat is particularly acute since there is a growing and determined movement in this country to restrict or prohibit the use of laboratory animals through both national and local legislation and regulation. Determined efforts are needed to restrict burdensome and unnecessary regulation and to make clear the toll such regulation exacts in inhibiting the flow of scientific discovery.

Concern is mounting about the inadequacy or obsolescence of research facilities and equipment. Restriction of funds for construction or renovation and for larger scale equipment purchase has taken its toll and efforts underway to assess the needs of the research universities and to seek sources of funding for capital improvements are timely.

Strategies

I. Efforts to improve the funding for biomedical and behavioral research and specifically to support the programs of the NIH have been an urgent priority of CAS, and it is clear that this emphasis and effort should continue. The

pressures of the present economic climate mandate that AAMC continue a strong advocacy role for the benefits of basic and clinical research and speak to the urgent need for a continued investment in research when the primary concern of Congress and DHSS has shifted to cost containment and limitation of government expenditures in health care. The Council in its recent discussions recognized the need for concerted action across all academic disciplines and specialty interests and supported the concept that societies should seek broad-based increases in research funding rather than specific and restricted appropriations. Recent AAMC efforts to articulate general Principles for the Support of Medical Research and to provide vigorous leadership of an Ad Hoc Group on Medical Research Funding, which has in each of the last several years successfully produced a unified request for increased NIH/ADAMHA appropriations to which over 140 societies were signatories, are examples of such efforts.

- *Should CAS continue strong advocacy for biomedical research appropriations?*

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Individual societies can play key roles in educating the public, the media, and Congress concerning the importance and benefits of research and the national need for broad-based, stable research support. Individual societies have provided speakers bureaus, science writers conferences, extended meetings with key Congressional staff, and special sessions at their science meetings.

- Should CAS societies increase their individual advocacy of broad-based research support? Would they benefit from sharing their experiences with these efforts?

As a forum for a diversity of faculty viewpoints, the CAS might provide a valuable consensus view on Congressional or NIH/ADAMHA priorities within limited funding scenarios. Should policy on allocation of funds to types of programs (e.g., investigator-initiated vs. center grants) or types of research become a focus for CAS concern?

- o *Should CAS provide a forum for discussion and development of policies to balance competing interests in an atmosphere of constrained funding?* 11
- o *Should CAS devote specific effort to concerns expressed for the deteriorating condition of research facilities/equipment at grantee institutions?* 12

II. Research training and faculty development are important priorities for academic societies. What strategies will be useful to ensure continued support of an optimal educational milieu for the training of future medical research personnel?

- o *Should CAS continue, as a high priority, efforts to achieve increased funding for research training?* 13
- o *Should CAS examine the present national research training effort and debate such issues as balance between different types of training (MSTP, fellowships, institutional training grants), trainee stipend levels, and appropriate length and methods of training?* 14
- o *Should CAS focus more effort on examining policies and initiatives for support of junior research faculty/new investigators?* 15

o What roles do individual societies play in faculty development within their own disciplines? What more could be done in this regard?

III. Research is best conducted in a milieu which has appropriate safeguards for health, environmental quality, and humane treatment of research subjects from human to invertebrate. However, excess regulation, burdensome paperwork, and attempts to interdict whole areas of research must be resisted. Currently the greatest threat in this arena lies in efforts to restrict the use of animals in research. AAMC, in conjunction with the AMA and American Physiological Society, has recently assumed a leadership role in building a coalition of concerned societies and coordinating their efforts in this area. Should CAS become more active in identifying roles which individual scientists and societies can play in this regard?

o *Should CAS and individual academic societies involve themselves wholeheartedly in efforts to limit restrictions on the use of animals in research?*

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Challenges in Patient Care

Background

The patient care environment of our medical schools has changed dramatically in the past twenty years, and it appears clear that we are on the verge of a new set of sweeping changes. Since the early 1960s academic medical centers have grown in size and complexity; they have expanded their high technology and tertiary care capabilities and serve as regional and in some cases national referral resources. They have continued their traditional role in service to the medically indigent, but they also acquired new patients

and new sources of income with the advent of Medicare/Medicaid. Medical service income has expanded from 6 percent to 30 percent of the annual income of the medical schools. Full-time faculty in the clinical disciplines have grown from 7,200 in 1961 to 40,148 in 1982. Many faculty are increasingly engaged in fund-generating clinical activities, and faculty practice plans have emerged as a management system for faculty effort devoted to reimbursable patient care. Faculty members have been part of a philosophic effort to bring high quality health care to all Americans and have accomplished this by expanded patient care efforts in the medical center, outreach and community programs, and education of a larger yearly cohort of new physicians for the nation.

Recently, the rapid growth of health care expenditures as a proportion of GNP has shifted the philosophic emphasis from providing universal access to quality care to providing cost-efficient care. Those paying for medical care have rapidly induced a shift to cost containment strategies such as HMOs, preferred provider plans, and prospective payment by diagnosis rather than cost reimbursement. For-profit concerns are becoming increasingly involved in the "business" of medical care delivery.

The Issues

From the perspective of the faculties, the overriding priority is to assure that patients receive scientifically based, high quality care. There is great concern to be sure that strategies to control costs do not have an adverse impact on the ability to deliver quality care. Faculty members are sensitive to the difficulty in developing quantifiable, objective measures of quality care once one begins to compare outcomes more subtle than survival rates. But they are also best positioned as the leaders in research and innovation in care to establish the norms and protocols by which care by

all providers should be judged. The academic community can also encourage the development of pricing and reimbursement systems which value cognitive skills as well as procedures.

There is concern about how successfully the academic medical center, by its very nature, can adapt to a competitive environment. Faculties have multiple missions and traditionally, generating a profit, or even staying out of the red, has not been one of them. Patient care activities have been viewed in the context of the types and number of patients needed to provide a balanced educational program, the spectrum of cases necessary to meet particular clinical research needs/interests of faculty groups, and the uniquely challenging diagnostic and management dilemmas whose referral and successful resolution marked the medical center as an academic resource. Additionally, the charitable obligations, especially of the large urban public hospitals, have loomed large. The emphasis has been much more on inpatient care than on long term, primarily ambulatory, care. While there has been growing dedication in the last decade to recovering all reimbursable costs for faculty efforts in patient care, programmatic decisions have traditionally not been based on patient revenues.

Faculties are concerned that attempts to position the academic medical center, or any of its individual hospitals and clinics, in a more fiscally competitive position include full consideration of the resources necessary to the teaching, research, and more traditional patient care missions. They are concerned that faculty members have an opportunity to understand the economic issues and participate in formulating policies related to patient care and resource allocation, especially for scarce, high technology resources. There is general recognition that some economies can be realized

by better management of hospitals but concern that costs are ultimately not as controllable in teaching as in non-teaching settings. It is important that policy decisions affecting patient care not be made under the guise of management efficiency without due deliberation and consultation with the faculty and medical staff.

Pressures appear to be building towards the development of multispecialty group practices of faculty designed to provide competitive primary care so as to ensure a steady source of patients for the academic center. There is concern for how academic centers with strong inpatient and referral emphasis can reorient themselves and continue to maintain a balanced commitment to education and research. Decisions will have to be made about the balance between primary care and subspecialty faculty which such an orientation may require and the balance between faculty primarily devoted to patient care and those primarily engaged in research. Equitable promotion and tenure policies will need to be developed that accommodate faculty predominantly engaged in only one of the three traditional roles, to ensure a mutually supportive and multidimensional faculty.

Issues related to medical education remain a high priority. The faculty time, patient time, and physical resources necessary to run a good clinical teaching program seem at odds with a streamlined, efficient, and cost cutting approach to care. While we must teach cost conscious practice to students, the teaching process, as distinct from the outcome, is time and resource intensive.

Challenges to graduate medical education are also emerging. Government and third party payors are increasingly reluctant to allow for house staff stipends and the increased patient care costs of the teaching setting. The traditional support of this large component of physician education and of

patient care seems to be eroding, and there is no readily identifiable alternate source of revenue.

Faculties also anticipate the possibility that the combination of pressures to limit payment for graduate medical education and the predicted surplus of physicians may lead to increasing efforts to curtail or alter the specialty distribution of physicians in training.

Strategies

I. A high priority of the faculties is to insure a continued emphasis on quality in the context of, and, if necessary, in contradistinction to, economical health care.

- o *Should CAS continue to emphasize, in all appropriate contexts, the concern of academic medical centers and their faculties for quality of health care?* 17
- o Can individual societies play a role in determining or promulgating norms or standards for quality patient care within their disciplines? How?

II. Attempts to make the academic medical center more fiscally competitive or promote marketable services must be made with full awareness of the impact of these policies on the education, research, and traditional patient care missions of the faculty and with the active participation of faculty in establishing such policies and resource allocations.

- o *Can CAS play a role in facilitating cooperation between faculties, deans, and hospital executives in formulating policies related to patient care?* 18
- o *Should CAS play a role in bringing together faculty members active in governance of their institutions' practice plans to exchange ideas and address shared concerns?* 19

- o *Should CAS gather and disseminate information on different organizational models for faculty practice plans?* 20
- o How can faculties and academic societies participate in scarce resource allocation decisions?

III. Faculties must position themselves to maintain their prerogatives as the ultimate decision makers in the diagnostic evaluation and management of patients. A century of efforts to pull medical decision making onto a scientific base must not be undone and an economic base substituted. Various future scenarios for payment of physicians would not only limit payment but shift control of some aspects of clinical care from physicians to administrators.

- o *Should CAS begin to examine proposed plans for future third party reimbursement of physicians?* 21

IV. Large scale group practices providing patient care services across the primary-to-tertiary and ambulatory-to-ICU spectra may become the future model for faculty efforts in patient care. Pressures to increase involvement in such large scale patient care efforts may conflict with other faculty missions and some predict they will lead to the development of clinical practice and research faculty tracks.

- o *Should CAS become involved in policy issues related to faculty practice efforts and their relation to the overall academic missions of faculty?* 22

V. Concern for medical education conducted in the context of patient care remains a high priority for faculty. Efforts are necessary to assure the proper sites, facilities, and types of patients necessary for their graduated teaching tasks from beginning medical students through research fellows. Threats to financial support of graduate medical education are emerging and are most germane to the clinical faculty in their disciplinary roles.

- o *Does CAS support the establishment of an AAMC-wide Task Force on the funding of graduate medical education?* 23
- o *As a sequel to the Report of the Panel on the General Professional Education of the Physician, should CAS pursue efforts to define the settings and resources necessary for each stage in the clinical education of a physician?* 24
- o Should individual academic societies be encouraged to undertake efforts to examine the resources and manpower necessary for clinical training in their disciplines?

FUTURE DIRECTIONS FOR THE COUNCIL OF ACADEMIC SOCIETIES

Background

The 1965 report authored by Lowell Coggeshall entitled "Planning for Medical Progress Through Education" had a profound effect on the AAMC. One of the recommendations was that a Council of Faculty should be established. The report states, "This Council should provide for all participation of faculty representatives, selected for their broad interest in education for health and medical sciences. It should be concerned primarily with matters of curriculum, education content, and educational methods."

The concept of a Council of Academic Societies as the mechanism for faculty representation to the AAMC was developed by a Task Force chaired by Dr. Kenneth Crispell, Dean of the University of Virginia. In September 1966 the Task Force presented the following recommendations to the Executive Council.

"We recommend the formation of a Council of Societies.

1. An Academic Society is defined as a society which has as a prerequisite for membership appointment to a medical school faculty or a society which in the opinion of the Executive Council of the Association of American Medical Colleges has as one of its major functions a commitment to the problems of medical education.

2. The societies to be represented on the Council of Academic Societies will be proposed by the Executive Council and determined by a vote of the institutional members.

3. To form the Council, each of the selected societies will be asked by the Executive Council of the AAMC to designate two members, one of whom shall be a department chairman and one a faculty member not holding a major administrative position.

4. The Council of Academic Societies will nominate four members to the Executive Council of AAMC--two from the basic sciences and two from the clinical sciences.

5. In those teaching disciplines in which such societies do not now exist, the teaching discipline may be given the same consideration as academic societies for membership in the Council of Academic Societies and be invited to nominate two members to the Council of Academic Societies. Subsequently, they may be encouraged to form such a society.

6. This Council of Academic Societies would be encouraged to function as an integral part of the regional organization of the AAMC."

Twenty-two societies were represented by 44 individuals at the first meeting of the Council of Academic Societies on October 27, 1967. In addition to the adoption of a constitution and by-laws, the Council discussed what the parameters of its agenda should be.

"The Council should seek to develop an action role for itself. The Council should avoid any tendency to become a debating society at which nothing more was accomplished than speech making. Rather, the Council should address itself to problems that were general enough to concern many, not so global as to present the temptation to allow escape into dialectic, well enough circumscribed so that they were solvable and important enough so that the answer when arrived at would be worth having. The committee suggested that the most immediate problem on which this Council should focus its attention was the general area of health manpower. They further suggested that problems in faculty development would be a fruitful place for the Council to begin. Other areas of potential interest include the nature of the bottleneck preventing the rapid expansion of medical schools and some of the problems which the further interdigitation of residents into the programs of medical centers will occasion."

At the second meeting in October 1968, the first CAS chairman, Thomas Kinney, Professor and Chairman of Pathology at Duke, told the Council:

> "The CAS is now in a position to carry out its main objectives: (a) to bring the medical college faculty into more active participation in the programs of the AAMC, (b) to enhance the medical school faculties' awareness of the national scope of the demands made upon medical education, and (c) to serve as a forum in which faculty opinion is given recognition in the formulation of national policies in the whole span of medical education.
>
> "The CAS, then, expects to be active in medical academic affairs. It is generally agreed that the 3 major areas of concern of the faculty of any medical center are: (a) the students, including their selection and the development of their intellectual and nonintellectual characteristics; (b) the curriculum, its content and methodology of presentation; and (c) the faculty itself, which includes the training, recruitment, and development of the faculty."

In 1969 John Cooper became President and completed the move of the Association to Washington D.C. This transition enhanced the emphasis on AAMC's becoming a major voice in national policies affecting medical education, biomedical research, and medical care. For the Council of Academic Societies, a strong and persistent focus on biomedical research policy and funding evolved, and in the early 1970s the Division of Biomedical Research and Faculty Development was established with Michael Ball, immediate past President of the AFCR, as its first Director. That office has been the central focus of the CAS, and the plateauing and

downturn of federal support for biomedical research and the reduction of research training opportunities have become major continuing concerns of the Council. Other national policy issues have included the clinical laboratory improvement act, Medicare reimbursement of physicians in a teaching setting, ethical standards in research, amendment of the National Labor Relations Act to permit unionization of house staff, and animal research legislation. Although medical education issues have been a part of many CAS programs, only one has caused widespread debate among member societies and that is the role of the National Board of Medical Examiners in certification for medical licensure and for medical student and medical education program evaluation.

Member Societies

There has been no attempt to seek the membership of academic societies in CAS; however, membership has grown steadily and in 1984, 76 societies are represented. Table II displays the current representation of academic disciplines in CAS and Table III the membership by society. It is clear that all of the major medical academic disciplines are represented to some degree although there are no formal "disciplinary chairs" on the Council, and some disciplines are represented by a number of societies.

Members of the Council of Deans and the Council of Teaching Hospitals hold their membership in those Councils by virtue of their professional positions. For both deans and teaching hospital executives, these are the principal national organizations that are concerned with their day to day interests and responsibilities. While CAS societies appoint representatives to participate in the business of the Council, the professional interests and responsibilities of these representatives are often only tangential to the activities of the CAS and AAMC. Further, representatives rarely can

Table II

Disciplinary Affiliation of Societies in CAS

DISCIPLINE	Chairman's Group	Research Society	Education Society	General Society
BASIC SCIENCES				
Anatomy/Cell Biology	1	2		
Behavioral Science			1	
Biochemistry	1	1		
Genetics		1		
Microbiology	1			
Neuroscience		1		
Pathology	1			1
Pharmacology	1	3		
Physiology	1	1		
Preventive Medicine			1	
CLINICAL SCIENCES				
Allergy				1
Anesthesiology	1	1		
Critical Care				1
Dermatology	1			
Emergency Medicine			1	
Family Medicine	1		1	
Internal Medicine	1	7	1	1
Neurology	1	2		1
Obstetrics-Gynecology	1	1		1
Pediatrics	1	2		
Physical Medicine/Rehab	1			1
Psychiatry	1	1	2	1
Radiology	1	1		
Surgery				
General	1	4		1
Neurosurgery	1			
Ophthalmology	1			1
Orthopedics	1			1
Otolaryngology	1	1		
Plastic Surgery		1	1	1
Thoracic Surgery	1			
Urology	1			

Table III: 1983-84 Membership List for the CAS

BASIC SCIENCES

ANATOMY
- American Association of Anatomists
- Association of Anatomy Chairmen

BEHAVIORAL SCIENCE
- Association for the Behavioral Sciences and Medical Education

BIOCHEMISTRY
- American Society of Biological Chemists, Inc.
- Association of Medical School Departments of Biochemistry

CELL BIOLOGY
- American Society for Cell Biology

GENETICS
- American Society of Human Genetics

MICROBIOLOGY
- Association of Medical School Microbiology Chairmen

NEUROSCIENCE
- Society for Neuroscience

PHARMACOLOGY
- American College of Neuropsychopharmacology
- American Society for Clinical Pharmacology and Therapeutics
- American Society for Pharmacology and Experimental Therapeutics
- Association for Medical School Pharmacology

PHYSIOLOGY
- American Physiological Society
- Association of Chairmen of Departments of Physiology

CLINICAL SCIENCES

ALLERGY
- American Academy of Allergy

ANESTHESIOLOGY
- Association of University Anesthetists
- Society of Academic Anesthesia Chairmen

CLINICAL RESEARCH
- American Association for the Study of Liver Diseases
- American Federation for Clinical Research
- American Society for Clinical Investigation
- Central Society for Clinical Research
- Plastic Surgery Research Council
- Society for Gynecologic Investigation
- Society for Pediatric Research

DERMATOLOGY
- Association of Professors of Dermatology, Inc.

EMERGENCY MEDICINE AND CRITICAL CARE
- Society of Critical Care Medicine
- Society of Teachers of Emergency Medicine

NDOCRINOLOGY
- Endocrine Society

AMILY MEDICINE
- Association of Departments of Family Medicine
- Society of Teachers of Family Medicine

ENERAL SURGERY
- American Association for the Surgery of Trauma
- American Surgical Association
- Association of Academic Surgery
- Society for Surgery of the Alimentary Tract, Inc.
- Society of Surgical Chairmen
- Society of University Surgeons

ITERNAL MEDICINE
- American College of Physicians
- Association of American Physicians
- Association of Professors of Medicine
- Association of Program Directors in Internal Medicine
- American Gastroenterological Association
- American Society of Hematology

NEUROLOGY
- American Academy of Neurology
- American Neurological Association
- Association of University Professors of Neurology
- Child Neurology Society

NEUROSURGERY
- American Association of Neurological Surgeons

OBSTETRICS AND GYNECOLOGY
- American College of Obstetricians and Gynecologists
- Association of Professors of Gynecology and Obstetrics

OPHTHALMOLOGY
- American Academy of Ophthalmology
- Association of University Professors of Ophthalmology

ORTHOPAEDICS
- American Academy of Orthopaedic Surgeons
- Association of Orthopaedic Chairmen

OTOLARYNGOLOGY
- Association of Academic Departments of Otolaryngology
- Society of University Otolaryngologists

PEDIATRICS
- American Pediatric Society
- Association of Medical School Pediatric Department Chairmen, Inc.

PHYSICAL MEDICINE AND REHABILITATION
- American Academy of Physical Medicine and Rehabilitation
- Association of Academic Physiatrists

PLASTIC SURGERY
- American Association of Plastic Surgeons
- Plastic Surgery Educational Foundation

PSYCHIATRY
- American Association of Chairmen of Departments of Psychiatry
- American Association of Directors of Psychiatric Residency Training
- American Psychiatric Association
- Association of Academic Psychiatry
- Association of Directors of Medical Student Education in Psychiatry

RADIOLOGY
- Association of University Radiologists
- Society of Chairmen of Academic Radiology Departments

THORACIC SURGERY
- American Association for Thoracic Surgery
- Thoracic Surgery Directors Association

UROLOGY
- Society of University Urologists

HEALTH AND HUMAN VALUES
- Society for Health and Human Values

PATHOLOGY AND CLINICAL LABORATORIES

- Association of Pathology Chairmen, Inc.
- Academy of Clinical Laboratory Physicians and Scientists

PREVENTIVE MEDICINE

- Association of Teachers of Preventive Medicine

speak for their societies because the timing of CAS meetings and the timing of member society meetings do not permit most societies to consider items on the CAS agenda in advance of a CAS meeting.

Governance

The entire Council meets biannually. A program is planned which permits in-depth consideration of a topic of major interest to academic faculty, and, at the business meeting, there is an opportunity for discussion of some of the major areas in which AAMC/CAS has taken or is considering action. This forum provides for the expression of diversity of opinion on issues, after which a general sense of the Council is sought to aid the Administrative Board in its deliberations.

The CAS Administrative Board is made up of twelve representatives (6 basic science/6 clinical science) selected from the Council at large, and includes a chairman, chairman-elect and immediate past-chairman. All nominations for these positions are made by a Nominating Committee drawn from the Council at large with no more than 2 of 7 members from the present Board. The Board meets four times a year to deliberate on a wide range of issues affecting the medical schools and academic medical centers and endeavors to provide a faculty perspective. The COD, COTH and OSR Boards meet simultaneously.

The restructuring of the AAMC which established three Councils could have resulted in a tripartite organization with each Council conducting its own affairs and carrying out its own programs with only modest overlap. Instead, the three Councils and the OSR have developed a mode of operation that presents all matters before the Executive Council to the Administrative Boards before final action is taken. The bulk of time at Administrative Board meetings is spent on items in the Executive Council agenda, and most issues are resolved by consensus. Rarely have ad hoc committees composed

entirely of members of a single Council been established, and the only standing committee of the CAS is the nominating committee. Conversely, Association committees are always composed of representatives from all three Councils, although the balance of representation may vary depending upon the charge to the committee.

This mode of deliberation and governance has been successful. It has promoted unity of purpose and has allowed the three major elements of academic medical centers to speak with one voice. Administrative Board members have been privileged to examine issues of principal concern to the other Councils and have gained insight into the complexity of the biomedical education, research, and service enterprise.

The position of each Board is taken by its representatives to the Executive Council meeting where AAMC positions are finally developed. The CAS has four representatives on the 23 member Executive Council. The past chairman, chairman, and chairman-elect and one other Administrative Board member represent the CAS. The remainder of the Executive Council is composed of four COTH representatives, two OSR representatives, nine COD representatives, a distinguished service member and the officers of the Assembly.

The complexity, multiplicity and diversity of the issues addressed, together with the rapidity with which developments occur on the national scene, has required the growth of a full-time professional staff not otherwise occupied with institutional responsibilities. The AAMC staff has played an increasingly prominent role in identifying issues and analyzing their implications, proposing responses, and coordinating deliberation by the constituencies. At times when rapid response is required the process has involved only the officers of the Executive Committee and those Board or

Council members most directly affected or with possible legislative influence.

The Issues

The difficulty of allowing due deliberation and expression of a diversity of opinion while achieving consensus for rapid action has been a source of concern to each of the Councils; this tension between debate and decision, between rank democracy and representative oligarchy, characterizes the governance of most organizations, including our medical centers themselves. CAS members have expressed concerns about representational duties when their societies do not meet frequently nor specifically debate AAMC/CAS issues and about Administrative Board representation of their concerns when the Council only meets biannually. Concerns about representation and delegation of decision-making power are highlighted by the difference between CAS and the other Councils where the medical schools and teaching hospitals are represented, qua institutions, by those with decision-making authority. Others view the organization of the CAS as a system for selecting a representative cross-section of faculty interested and involved in the issues who will then function as a collective faculty body at the national level.

There is concern about the depth of expertise faculty can bring to debate on those issues which they confront briefly two or four times yearly. There is a desire to use meetings as an opportunity for education but also a desire for more active discussion and less time spent in passive information transfer.

CAS members also realize the value inherent in the diversity of their Council. They see Council meetings as one of the few opportunities for interdisciplinary conversation across a variety of issues and disagreement as valuable, not necessarily divisive. Some have expressed the hope that, through this Council, societies and faculties could learn to collaborate across disciplines. The lessons learned could be applied to enhance the

ability of faculty to collaborate between disciplines and across the basic-to-clinical science spectrum in teaching, to collaborate between disciplines and across the M.D.-Ph.D. spectrum in research, and to collaborate between disciplines and across the primary-to-tertiary care spectrum in patient care.

Strategies

I. The present structure of the Council of Academic Societies is affirmed as an effective and flexible means of assuring faculty participation in the governance of the AAMC across a broad range of disciplines and perspectives. Biannual meetings of the entire Council serve as a forum for in-depth examination of major issues of concern to the faculties and the AAMC, and an opportunity for expression of a diversity of views. The CAS Administrative Board, with its balanced representation of basic and clinical science societies, meets quarterly to debate issues of particular concern to the CAS and to provide a CAS perspective on issues facing the Executive Council of the AAMC. Since 1974, representatives from 22 different societies have filled the 29 positions which have come open on the Administrative Board.

II. Communication and cohesiveness have been highlighted as challenges for a Council which convenes biannually. Mechanisms should be sought to enhance communication between the representatives of the 76 member societies and the Administrative Board. To facilitate such communication, minutes of each Board meeting could be transmitted to the member society representatives. Another mechanism to promote communication would be to attempt to identify key long range issues which will be debated by the Administrative Board and Executive Council in the future and to provide an opportunity for individual society representatives to communicate their views to Administrative Board members.

Although all CAS Representatives receive the AAMC Weekly Activities Report which keeps them abreast of key issues and of positions or actions

taken by the AAMC, it might also prove effective to seek a feasible method for summarizing yearly the agenda of major issues debated by the CAS and soliciting representatives' recommendations about future agenda items.

III. The Administrative Board believes that ad hoc Working Groups or Task Forces of the CAS should be established on occasion to deal with specific issues in depth. Such groups with a specific charge and a membership drawn from relevant Council and Board members will be able to address specific policy issues and provide guidance to the Board in its deliberations. Members of the CAS will also continue to be active participants in AAMC-wide Task Forces. The CAS does not believe that standing committees are as effective a mechanism for dealing with diverse and rapidly changing issues as ad hoc groups which provide specific focus and flexibility.

Present examples of such efforts include the formation in July 1984 of a CAS Working Group on the GPEP Report which will deliberate the AAMC response to the Panel's Report and lead an in-depth discussion of the GPEP recommendations by the full Council at the Annual Meeting. In July, the Association also formed an AAMC Task Force on Financing Graduate Medical Education whose members include representatives from three CAS societies. Since 1980 the AAMC has convened nine Ad Hoc Committees to address a variety of policy issues including Biomedical Research and Training (1979-81), Foreign Chartered Medical Schools (1980-81), Maintenance of High Ethical Standards in the Conduct of Research (1981-82), and Payment for Physician Services in Teaching Hospitals(1982-83).

IV. The membership of the Council of Academic Societies has grown steadily since twenty-two chartered societies participated in its formation in 1967. An average of 2-3 new societies have joined each year. Each society may appoint two official representatives to the Council, and although societies

are urged to select representatives who would be able to serve to the maximum term of eight years to provide continuity, there is substantial turnover in representation. To maximize the effectiveness of the Council an orientation packet should be prepared for new representatives to facilitate their rapid integration into Council function. The Administrative Board is also considering ways to communicate with each society about the role of the CAS and the desirability of active participation, and examining the possibility of a yearly orientation program at a Council meeting.

SUMMARY

This issues paper highlights many of the challenges which will face the faculty in fulfilling their traditional missions in research, education and patient care. It proposes strategies for dealing with some of these challenges which the CAS might consider adopting. It discusses the organization of the CAS itself and how it might be best structured to deal substantively with the issues which most concern it. In this preliminary overview of the challenges there has been little effort to establish priorities among the issues or between the missions of faculty. Nor has there been any consideration of how efforts to take on some of these issues might best be orchestrated, given limited financial and personnel resources for the CAS and the very busy schedules and multiple duties of faculty members.

This draft paper will benefit from comments by Council members on the issues, strategies, or mechanisms discussed. The consensus document emerging from this effort of the Council and Administrative Board should articulate a faculty perspective on the challenges facing academic medical centers and the AAMC in the near future. Council members should also give serious consideration to ways in which each member society is addressing those issues highlighted in

this white paper which are germane to its mission. The collective efforts of faculty members through their societies will be as necessary to success in meeting these challenges as any efforts of the Council as a whole.