



**association of american  
medical colleges**

**AGENDA  
FOR  
COUNCIL OF DEANS**

**ADMINISTRATIVE BOARD**

**WEDNESDAY, JANUARY 18, 1984  
4:15 P.M. - 6:15 P.M.  
EDISON ROOM**

**THURSDAY, JANUARY 19, 1984  
9:00 A.M. - 1:00 P.M.  
HAMILTON ROOM**

**WASHINGTON HILTON HOTEL  
WASHINGTON, D.C.**

FUTURE MEETING DATES

1984 AAMC Annual Meeting

*October 27 - November 1*  
*Chicago, Illinois*

1984 COD Administrative Board/Executive Council

*April 11-12*  
*June 13-14*  
*September 12-13*

1984 COD Spring Meeting

*April 1-4*  
*Callaway Gardens*  
*Pine Mountain, Georgia*

COUNCIL OF DEANS  
ADMINISTRATIVE BOARD

Wednesday, January 18, 1984

4:15 pm - 6:15 pm

Washington Hilton Hotel  
Washington, D.C.

AGENDA

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I. Role of COD Administrative Board and Relationship to the Council of Deans . . . . .	1
II. Issue Identification for COD White Paper . . . . .	3
III. COD Activities at Annual Meeting	
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V. General Professional Education of the Physician -- Dr. Muller	

Thursday, January 19, 1983

9:00 am - 1:00 pm

- I. Call to Order
- II. Report of the Chairman
- III. Approval of Minutes
- IV. Action Items
  - A. Definition of Enrollment  
(Executive Council Agenda-----p. 20)
  - B. American Council on Transplantation  
(Executive Council Agenda-----p. 22)
  - C. GAO Study of Supervision of Residents in VA Hospitals  
(Executive Council Agenda-----p. 28)
  - D. New Challenges for the Council of Teaching Hospitals  
and the Department of Teaching Hospitals  
(Executive Council Agenda-----p. 35)
  - E. Lengthening of Graduate Medical Education  
(Executive Council Agenda-----p. 93)

- F. Ratification of the Special Requirements for  
Transitional Year Programs  
(Executive Council Agenda-----p.95)
- G. NIH Renewal Legislation  
(Executive Council Agenda-----p. 107)
- H. Research Facility and Equipment Needs  
(separate attachment)
- V. OSR Report
- VI. Old Business
- VII. New Business
  - A. Information on Medical Schools' Patent Policies, Small  
Business, and Entrepreneurial Involvement . . . . . 29
- VIII. Adjournment

*UNIVERSITY of PENNSYLVANIA*

SCHOOL OF MEDICINE


PHILADELPHIA 19104

Edward J. Stemmler, M. D.  
*Robert G. Dunlop*  
*Professor of Medicine*

*Office of the Dean*  
215-898-5181

MEMORANDUM

TO: Drs. Arnold L. Brown  
William T. Butler  
John E. Chapman  
D. Kay Clawson  
Robert S. Daniels  
Fairfield Goodale  
Richard Janeway  
Louis J. Kettel  
Richard H. Moy  
John Naughton  
M. Roy Schwarz

FROM: Edward J. Stemmler, M.D.   
Chairman of the Council of Deans

DATE: December 14, 1983

SUBJECT: January 18th & 19th Meeting of the Administrative Board

I have asked Joe Keyes to schedule the beginning of the next meeting of the Administrative Board for 4 PM on Wednesday, January 18th, to allow for a two and one-half hour period prior to our cocktail party for discussion of several items concerning the Board. I do hope that all of you can arrange your schedules to be in attendance at that time.

It has become clear that the time allotted for the business of the Administrative Board does not allow for discussion of any items of new business nor for the identification and formulation of ideas which we wish to have explored by AAMC staff in our behalf. Rather, the role of the Administrative Board has been essentially a responsive one. Accordingly, I would like to have the members of the Administrative Board come prepared for a discussion of the role of the Administrative Board and a view of the relationship between the Administrative Board and our constituent group, the Council of Deans. It seems proper to examine this question in some depth so that we might come prepared to promote a more extensive discussion

of this question at the Spring Meeting of the Council of Deans. Many of our colleagues feel disconnected from the central activities of the AAMC and it is certainly our responsibility to do what we can to minimize those feelings.

A second item for discussion is the need for the Administrative Board of the Deans to produce an issue paper, comparable to a White Paper produced by the Council of Teaching Hospitals, which sets forth the main forces on the horizon of medical educational institutions, forces that should command the attention of our AAMC Staff. Joe Keyes has been instructed to write such a paper and I ask that each of you come with a list of the areas or items that you see are of enough concern to be dealt with in this document.

I would like also to discuss the possibility of establishing a program for the Fall Meeting of the Council of Deans, the meeting which has traditionally been merely a business meeting at the national meeting of the AAMC. It is my personal view that the deans could well use one additional programmatic meeting to supplement programs which have, to date, been limited to the Spring Meeting. Please consider this question and come prepared with some ideas.

A final item for the Wednesday afternoon session will be a brief discussion of the Spring Meeting program.

There was a thoughtful and constructive discussion of the GPEP Committee and its perception by the deans at the recent AAMC Officers' Retreat. I believe that there is a deep concern on the part of the AAMC Staff and the leadership of the other councils about the deans disaffection with this important effort. It is my hope that we can have a serious discussion on this subject on the evening of Wednesday, January 18th. It is important that we, as members of the Administrative Board, reason out the mechanisms that might be used to convert the deans' view from that of passive, sullen acquisition into a more active, constructive group. I believe there are some specific actions which we can take toward that end. For the moment, John Cooper and Gus Swanson will attempt to persuade Steve Muller and his committee to avoid the publication of a "final" document and, instead, present a document which may be made available for discussion by the deans. Whether or not this occurs, we continue to have a responsibility to act constructively for the good of medical education.

You will hear from Joe Keyes with the standard agenda which is the business for the Thursday morning session and, for those of you who are members of the Executive Council, for the Thursday afternoon session as well.

I look forward to a constructive meeting.

EJS/mmcd

cc: Joseph Keyes, J.D.

## FUTURE DIRECTIONS FOR THE COUNCIL OF ACADEMIC SOCIETIES

At the annual Officers Retreat an examination of the membership, activities, and future challenges for the Council of Teaching Hospitals was reviewed. There was a consensus that a similar examination by the Council of Deans and the Council of Academic Societies is timely. The following is presented to assist the Administrative Board in its consideration of how a useful examination of the membership, activities, and future challenges for the Council of Academic Societies might be conducted.

### Establishment and Early History

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. These were accepted and in October 1966 approved by the institutional membership.

"We recommend the formation of a Council of Academic 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 the 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."

The first organizational meeting of the Council of Academic Societies was held in January 1967. The summary of that meeting is included because it illustrates the range of concepts of what the role of the Council of Academic Societies might be in the AAMC, the academic community, and the national structure of medicine and the biomedical sciences.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ORGANIZATIONAL MEETING OF THE COUNCIL OF ACADEMIC SOCIETIES

January 10, 1967

Ramdada Inn-O'Hare, Chicago, Illinois

**PRESENT:** William N. Hubbard, Jr., Chairman  
Robert C. Berson  
Cheves McC. Smythe

George Aagaard  
Eben Alexander, Jr.  
John A. Campbell  
Philip P. Cohen  
Kenneth R. Crispell  
James B. Snow, Jr.  
Donald Duncan  
Harry A. Feldman  
Patrick J. Fitzgerald  
Robert E. Forster  
A. Donald Merritt

Thomas D. Kinney  
A. Edward Maumenee  
Jonathan Rhoads  
Morris Frank Shaffer  
Robert Slater  
Daniel C. Tosteson  
Raymond F. Waggoner  
James V. Warren  
Ralph Wedgwood  
Robert H. Williams  
Russell T. Woodburne



Dr. William N. Hubbard, Jr., as Chairman, opened the meeting at 10:00 a.m. January 10, 1967 with a charge to the group present that they use the first hours of the meeting to examine the organizational structure proposed in the memorandum submitted to them. The purpose of the meeting is to find a way to include faculty in an influential manner within the Association of American Medical Colleges so that as the AAMC continues in its six year experience with Federal Health it can be better informed and speak from a broader base of information than has been possible in the past. A Council of Academic Societies composed of faculty members from medical schools who were also representatives of established societies was envisioned in order to create a forum for faculty opinion and faculty representation in the AAMC. Faculties of medical schools should have an important formal position in the development of policies and positions of the AAMC and should participate in the formulation and announcement of all policies. Simple faculty representation would not take the AAMC beyond past efforts, whereas the idea of professional societies would provide some kind of unifying forum for the individual societies to come together and provide a basis for consideration of postgraduate training and continuing education programs in the future. Those present were not asked to conform to a fixed pattern but to suggest ways and means by which the AAMC could get faculty representation. Those present were asked to identify an organizing committee that would deal with the issues to be raised. The group was charged not to predict the formal, final membership, but to have enough representative quality so that it would be a reasonable group from which to arrive at a definition of the ultimate. The AAMC is a part of a university community which itself is rapidly changing. Just as a total university community finds itself organizing itself nationally, so must the AAMC as part of that community.

Dr. Philip P. Cohen stated that he thought the aims should be not to represent the faculties but rather the areas of activity with which the faculties identified. He felt that by encompassing all the different professional societies under a formal identification by saying the AAMC had a liaison of some type with them would be a sectarian view and such an umbrella approach to gain a loud voice for the AAMC would be unfortunate. He suggested only identification with medical school departments would have a meaningful impact on society -- an opportunity for the individual faculty member to define what his area is, how his area is represented. The scope and breadth of new thinking and fresh ideas would not come from the professional societies because they would defend their own positions and would not represent radical and bold ideas. He thought the AAMC should exploit those areas in the university that are not having an impact on medical schools today but would have in the future, such as engineering, schools of education, undergraduate programs, etc. He charged the approach as being sectarian by restricting the group to only those societies that represent the components of the medical faculty. He proposed a group of advisory councils: education methods and procedure, a research component, the clinical service function, and administration of education for the deans. He said it is important to get away from the idea of representing faculty and to represent those segments of interest which are identified as rallying points for those interested in teaching and research.

Dr. Jonathan Rhoads suggested that the representative side as outlined in the submitted report be a rotating group of people. He thought there would be relatively few people who would serve over two years, many perhaps a year. He suggested that that kind of a constituency was valuable as a feedback mechanism but cannot gain great power or authority as a put-in mechanism. He thought it would be useful to provide some sense of participation and keep a large number of key professional societies informed about what the AAMC was endeavoring to do, but it would need to be supplemented by a group of people who could serve on a longer term basis because of what they have to give. These people could be developed from the transient representatives of societies and some could be developed in other ways to provide an effective in-put. He suggested that people have to stay with a thing over a considerable period of time to be effective.

Dr. Ralph Wedgwood proposed that the Council be flexible so that stepwise they could incorporate the expanding role of the AAMC, expanding from a primary role or interest in the process of medical education, to that of the education of physicians and the education of health professions. He suggested a harder definition of the organizations that should be given representation on the Council be made. Organizations which should be represented should have as a primary requisite, that of an academic position on a University faculty. The organization must represent all of the universities involved in the process of medical education. He felt that department chairmen need to be involved in the AAMC council process.

Dr. Thomas Kinney suggested that by looking back to see who the past presidents of the various societies have been for the past 15 years, and by looking at their constitutions, organizations which might be included could be identified. He thought the important thing was to get on with a structure that would bring together men representing the various disciplines that are concerned with teaching in medical schools, problems relating to education, research, building, government, financing, etc. He said he found the Millis Report unacceptable and had the AAMC been more aggressive it would have been able to present a plan which would have been accepted. He advised everyone to keep an open mind, suggested the Council of Academic Societies would function all the way through the AAMC and said that no matter what was done at the meeting, even though it would be incomplete, it would be a start.

Dr. Robert Williams summarized the activities of the Association of Professors of Medicine, the Medical Intersociety Council, and the Research Societies Council.

Dr. Hubbard presented names proposed as an organizing committee, Dr. Thomas Kinney, Chairman pro tem, Drs. Jonathan Rhoads, James Warren, Philip P. Cohen, Morris Shaffer, and Ralph Wedgwood.

Dr. Robert E. Forster said he had some fundamental questions he would like answered before voting.

Dr. Hubbard moved that decision on the committee be deferred until after lunch and further discussion.

The meeting adjourned for lunch, at 12:30 p.m.  
At 1:30 p.m. the discussion was resumed.

Dr. Robert E. Forster asked what sort of representation and control the professional societies and their representatives would have.

A discussion of some length ensued. It was decided the initial founding group should be small and representative of the major components of the faculties. There are no restrictions in preventing one of these people from becoming president of the AAMC. They should be distinguished in their fields and have membership in a distinguished society. The purpose of the CAS of the AAMC was defined as a forum in which the broadly represented consideration of medical educators could clarify attitudes and define responsibilities in guiding the development of local and national policies toward education in the universities, colleges, and medical centers, and in improving the health of the people.

A motion was made and carried that from this faculty group an organizing committee be formed with Dr. Thomas Kinney as Chairman pro tem, and other members of the committee being Drs. Rhoads, Warren, Cohen, Shaffer, and Wedgwood.

At 3:00 p.m. the meeting adjourned for coffee and was resumed at 3:20 p.m.

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.

The first program of the Council of Academic Societies focused on The Role of the University in Graduate Medical Education. In his introduction to the three day conference in October 1968, Thomas Kinney, Professor and Chairman of Pathology at Duke and first CAS Chairman, 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."

### Growth and Development

In 1969 John Cooper became President and moved 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.

The plateauing and downturn of federal support for biomedical research and the reduction of research training opportunities have been major continuing concerns of the Council. The combined AAMC/CAS leadership in working to maintain the programs of the NIH has been a significant factor in the growth of membership of the CAS. Except for the resignation of a few large societies, such as the American College of Surgeons, the American Academy of Pediatrics, and the American Psychiatric Association, when dues were increased in 1973, the membership in CAS has grown steadily from 22 to 76 societies. Other national policy issues that member societies have looked to the CAS for action on are the clinical laboratory improvement act, medicare reimbursement of physicians in a teaching setting,

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.

Since the early 1970s the member societies of the CAS have been encouraged to become politically active in Washington, and to establish policies and procedures that will allow timely responses to legislative or regulatory challenges. Because the level of interest in political affairs by organizations fluctuates with the changing membership of their officers and governing boards, the CAS has encouraged member societies to designate a public affairs representative who has a continuing interest in public policy and who is the Council's contact when action is needed. Workshops were held on two occasions for these individuals to inform them of how both the legislative and executive branches of government function. In addition, a quarterly news sheet, the CAS Brief, informing societies of pending, legislative, or regulatory issues was initiated and CAS Alert messages have been issued from time to time when action is needed. The Brief was cancelled in 1983. All CAS society representatives and officers now receive the more timely Weekly Activities Report.

Increasing interest in having a "Washington presence" resulted in the formation of the Council of Academic Societies' Services Program in 1977. The Association of Professors of Medicine, four neurological societies, and the AFMR are clients of the program. However, a number of CAS member societies have opted to either hire Washington lobbyists or to use the lobbying functions of their national professional college or academy. There is little question

that this movement toward societies seeking their own voice in national policy will grow.

#### The AAMC - A Consensus Organization with a Centralized Governance

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 of 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.

However, this experience has not been extended to the representatives of CAS member societies to a significant degree. The letter on page 23 from the representatives of the Association of University Anesthetists expresses feelings that are probably shared by many CAS representatives. In the main, CAS representatives and their member societies are recipients of information from the AAMC rather than initiators of input to the AAMC.

### A Diverse Constituency

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. The CAS constituency is composed of diverse academic societies (see page 25) that appoint representatives to participate in the business of the Council, but the professional interests and responsibilities of these representatives are only tangential to the activities of the CAS and AAMC. Further, representatives rarely can 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.

### Things to Consider

1. What are the issues and concerns that should be considered in an examination of CAS activities, modes of operation, and future challenges?
2. What procedures should be followed?
3. What should be the time course?



STANFORD UNIVERSITY MEDICAL CENTER

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STANFORD UNIVERSITY SCHOOL OF MEDICINE  
Department of Anesthesia

C. Philip Larson, Jr., M.D.  
Professor of Anesthesia

November 25, 1983

Virginia V. Weldon, M.D.  
Associate Vice Chancellor  
Washington University School of Medicine  
Box 8106, 660 S. Euclid Ave.  
St. Louis, MO 63110

Dear Dr. Weldon:

We are writing to you in our capacity as representatives of the Association of University Anesthetists to the Council of Academic Societies. First, we would like to congratulate you on your election as Chairman of the CAS Administrative Board. We wish you every success in the coming year.

An additional purpose in writing to you is to express our concern over the administrative functioning of the CAS, a concern that we believe is shared by many representatives to the CAS. Basically, the CAS meets formally twice a year, the meetings consist primarily of presentations by AAMC officials or academic leaders, and the CAS representatives return home until the next meeting. There is virtually no dialogue or interaction between the CAS Administrative Board and CAS representatives either during the two meetings or in the long intervals between meetings. CAS representatives receive regular communications from the AAMC, but by and large, the policies are determined and the plans of action are in place by that time. From our vantage point, it would seem that the CAS has no policies, no programs and no advanced input into the decision-making of the AAMC. The CAS representatives do little more than listen and rubber stamp what has already happened. In truth, the CAS meetings are nothing more than information sessions.

Even the business meetings of the CAS lack the realities of a business session. As one of many examples, the presentation at the most recent business meeting by the outgoing Chairman, Dr. Frank Wilson, was a thoughtful, scholarly, and intellectually challenging consideration of the subject of creativity, and it certainly deserves publication and wide review. However, it was presented at the wrong time and place. It should have been presented in the CAS morning program or among the general presentations of the AAMC. As a result of this and other presentations at business meetings, the agenda of the business meeting is always too full, there is little time for meaningful discussions of key issues among CAS representatives, and the representatives leave the business meeting without having developed any programs, policies or even a concensus on the major issues.

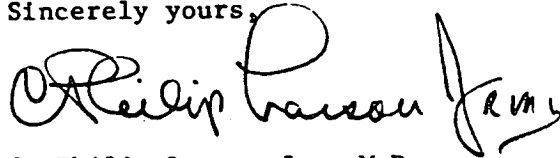
We believe that the CAS must modify the way it functions if it is to remain a viable entity by having a meaningful role in the future planning for academic medicine and the biomedical research enterprise. The CAS Administrative



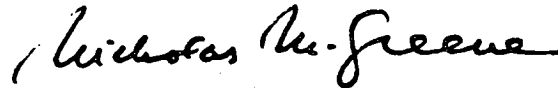
Board must find ways to increase the dialogue between itself and its member representatives. It must solicit the views of CAS representatives on key issues, propose policies or programs based on those views, attempt to develop consensus among the representatives for those policies or programs, or failing that at least articulate the major differing positions, and when consensus is reached, work toward implementation of those policies or programs through the AAMC. This may mean a restructuring of the CAS meetings, the periodic creation of subcommittees with defined tasks, or a variety of other alternatives. The AAMC cannot hope for unity and consensus among scientists if the CAS, a major and potentially influential scientific entity, does not even have a mechanism in place for developing either.

We offer this commentary and these suggestions in the spirit of and hope for an examination and discussion of the future role of the CAS. We believe that better mobilized and motivated, the CAS can be a more effective force in aiding the AAMC in presenting its programs and policies to Congress and the public.

Sincerely yours,



C. Philip Larson Jr., M.D.  
Professor of Anesthesia  
Stanford University School of Medicine



Nicholas M. Greene, M.D.  
Professor of Anesthesia  
Yale University School of Medicine

1983-84 Membership List for the Council of Academic Societies

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

ENDOCRINOLOGY

Endocrine Society

FAMILY MEDICINE

Association of Departments of Family Medicine

Society of Teachers of Family Medicine

GENERAL 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

INTERNAL 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

1984

SPRING MEETING  
of the  
COUNCIL OF DEANS

April 1-4, 1984  
*Callaway Gardens*

PROGRAM

**Sunday, April 1st**

1:00-5:00 pm, *Convention Lobby*  
ARRIVAL & REGISTRATION

SESSION I

5:30-7:00 pm, *Willow Room*  
WELCOME & OVERVIEW  
PRESIDENT'S REPORT  
John A.D. Cooper, M.D.

REFLECTIONS ON THE ADEQUACY OF  
HOUSE OFFICER SUPERVISION  
Richard Schmidt, M.D., *President*  
SUNY-Upstate Medical Center

7:00-8:30 pm, *Garden Patio*  
RECEPTION

**Monday, April 2nd**

SESSION II

8:30-10:30 am, *Willow Room*

Moderator: William T. Butler, M.D.

EXPLORING A RELATIONSHIP WITH A  
FOR-PROFIT HOSPITAL  
Ronald P. Kaufman, M.D.  
*Executive Vice President & Dean*  
George Washington School of Medicine  
and Health Sciences

MEDICAL SCHOOL/TEACHING HOSPITAL  
RELATIONSHIPS IN A  
CONTEMPORARY ERA  
Jerome H. Grossman, M.D., *President*  
New England Medical Center

10:30-11:00 am, *Willow Room*

BREAK

SESSION III

11:00-1:00 pm, *Willow Room*

Moderator: Richard Janeway, M.D.

AN INDUSTRIALIST'S PERSPECTIVE ON  
MEDICAL CARE COST CONTAINMENT  
J. Paul Sticht, M.D., *Chairman*  
R.J. Reynolds Industries, Inc.

Moderator: Fairfield Goodale, M.D.

ETHICAL ISSUES IN A COMPETITIVE/  
PROSPECTIVE PRICING  
REIMBURSEMENT SYSTEM  
Baruch A. Brody, Ph.D., *Director*  
Center for Ethics, Medicine & Public Issues  
Baylor College of Medicine

H. Tristram Engelhardt, Jr., Ph.D., M.D.  
*Professor*  
Dept. of Medicine & Community Medicine  
Baylor College of Medicine

1:00 pm

UNSCHEDULED TIME

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**Tuesday, April 3rd**

SESSION IV

8:30-10:30 am, *Willow Room*

Moderator: Edward J. Stemmler, M.D.

EDUCATING STUDENTS IN THE  
CLINICAL DISCIPLINES  
Sherman M. Mellinkoff, M.D., *Dean*  
UCLA, School of Medicine

10:30-11:00 am, *Willow Room*

BREAK

SESSION V

11:00-1:00 pm, *Willow Room*

Moderator: Arnold L. Brown, M.D.

EDUCATING STUDENTS IN THE  
BASIC SCIENCE DISCIPLINES  
Robert L. Hill, Ph.D., *Chairman*  
Department of Biochemistry  
Duke University School of Medicine

1:00 pm

UNSCHEDULED TIME

**Wednesday, April 4th**

SESSION VI

8:30-12 noon, *Willow Room*

COD BUSINESS MEETING

12 Noon

ADJOURNMENT

\* \* \* \* \*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

Thursday, September 22, 1983  
9:00 am - 1:00 pm  
Grant Room  
Washington Hilton Hotel  
Washington, D.C.

PRESENT

(Board Members)

Arnold L. Brown, M.D.  
D. Kay Clawson, M.D.  
William B. Deal, M.D.  
Fairfield Goodale, M.D.  
Richard Janeway, M.D.  
William H. Luginbuhl, M.D.  
Richard H. Moy, M.D..  
M. Roy Schwarz, M.D.  
Edward J. Stemmler, M.D.

(Staff)

David Baime  
Janet Bickel  
Robert Boerner, Ph.D.  
John A. D. Cooper, M.D.  
Sandra Garrett, Ed.D.  
Carolyn Henrich  
Paul Jolly, Ph.D.  
Thomas J. Kennedy, Jr., M.D.  
Joseph A. Keyes, Jr.  
James R. Schofield, M.D.  
John F. Sherman, Ph.D.  
Emanuel Suter, M.D.  
Kathleen Turner

(Guests)

Pamelyn Close  
Robert Keimowitz, M.D.  
Manson Meads, M.D.  
Richard S. Wilbur, M.D.

I. Call to Order

The meeting was called to order at 9:00 am.

II. Report of the Chairman

Dr. Janeway reported on several items considered by the Executive Committee at its meeting preceding the Board's:

- While recognizing that there are serious organizational and administrative problems in attempting to involve more fully and formally house officers in the AAMC, the Committee generally felt that since residents are a critical part of the medical education continuum and methods for involving

them in AAMC activities ought to be explored. Several suggestions were discussed including potential relationships with the CAS and the Group on Medical Education. The Executive Committee asked that the CAS Board discuss this matter at its next meeting and explore potential mechanisms for providing a more visible role for house officers without serious alterations to the present AAMC structure.

- Dr. Heyssel, Mr. Rice, Dr. Cooper, Dr. Knapp, and Dr. Sherman recently met with several members of the Board of the Association of Academic Health Centers to discuss the AAHC's desire to establish a joint task force with the AAMC for the purpose of addressing critical issues facing teaching hospitals in the decades ahead. Dr. Janeway reported that the Committee concluded that while the task force may not be the best mechanism, the AAMC should be open to considering ways of cooperating with the AAHC on matters of mutual interest such as this. The AAMC recognizes that vice presidents of academic medical centers, especially those involved directly with the hospitals, have a need to be kept abreast of the changing legislative and regulatory issues often discussed by hospital executives at COTH meetings.

Dr. Cooper stated that a similar need exists for the university presidents as illustrated by discussions at a recent Joint Health Policy Committee.

### III. Approval of Minutes

The minutes of the June 30, 1983 meeting of the Administrative Board were approved without correction.

### IV. Action Items

#### A. Blacks and the Health Professions in the 80's: A National Crisis and A Time for Action

The Association of Minority Health Professions Schools recently published a report entitled, "Blacks and the Health Professions in the 80's: A National Crisis and A Time for Action." Although many of the findings and recommendations of the report were congruent with the Association's 1978 Task Force on Minority Student Opportunities in Medicine, several of the report's findings were either not substantiated by the Association's data or referred to local situations inappropriate for the AAMC to address. Consequently, the staff did not recommend a blanket endorsement of the report, and prepared instead the following:

The Association of American Medical Colleges commends the Association of Minority Health Professions Schools for its timely report, "Blacks and the Health Professions in the 80's": A National Crisis and A Time for Action." This report

emphasizes many of the findings and recommendations of the AAMC's 1978 Task Force on Minority Student Opportunities in Medicine, and is welcomed as providing additional evidence in support of increasing opportunities for underrepresented minorities in all levels of medical education. The Association takes this occasion to re-affirm its support of this worthy goal.

Pamelyn Close reported that the OSR supported the staff recommendation, but suggested that it would appear somewhat less self-serving if the word "own" in the last sentence of the statement were deleted.

Dr. Janeway stated that in view of our role in the LCME the Association should not endorse a report that addressed issues linked to policies issues, such as the class size of individual medical schools. Board members observed that the nature of the media portrayal of educational opportunities for minority students was becoming increasingly negative.

Dr. Cooper reported that minority applicant pool had not increased over the past years and the percentage of minority students accepted into the health professions had remained relatively constant. In addition, he reported that the Association's Office of Minority Affairs is involved with three projects addressing issues related to the educational needs of minority students: recruitment, financial aid, and retention.

On motion, seconded, and carried, the Board endorsed the staff's recommended statement of commendation to the AMHPS with suggested editorial deletion.

#### B. COTH Membership Criteria

Dr. Knapp, Director of the Association's Department of Teaching Hospitals reported that the COTH Board had recently undertaken a review of COTH membership criteria. This was stimulated by several factors: (1) a recent analysis conducted by the department's staff had revealed that several members did not meet the current membership criteria because they did not sponsor, or significantly participate in, at least four approved residency programs or they had fewer than 30 FTE residents; (2) many hospitals have begun to establish multi-unit systems consortia or associations. The Board was concerned with the prospect that these groups would apply for COTH membership. If several members sought to be included under an umbrella membership, this would not only result in a reduction in dues revenue, but also would alter the relationships between the AAMC and the teaching hospitals if membership were in the name of a non-hospital entity.

However, because the COTH Board was considering an issue paper dealing with a large number of related matters, it had voted to defer action on changing this criteria for membership to a later time.



Discussion ensued regarding the likelihood of the for-profit hospitals seeking membership in COTH. Mr. Keyes reported that under the AAMC Charter and Bylaws, membership is limited to public institutions not-for-profit IRS 501(C)(3) organizations-- those organized and operated exclusively for charitable purposes. To change our membership criteria to permit for-profit organizations to join may raise serious questions regarding the AAMC's own tax exemption. The issue would be whether the AAMC was, in fact, providing services that served the profit-making objectives of certain of its members.

Mr. Keyes stated that if AAMC membership served only the educational programs of its members and prior approval was obtained from the IRS, one or two for-profit members would probably not affect the Association's tax status.

The Board urged that the staff continue to explore the implications of for-profit hospitals membership in the AAMC.

C. ACCME Protocol for Recognizing State Medical Societies as Accreditors of Intrastate CME Sponsors

Dr. Suter reported that the ACCME had recently met to discuss the Executive Council's dissatisfaction with the proposed protocol, specifically, the Council's recommendation that the ACCME retain the right to ratify or reject a decision by the Committee of Review and Recognition (CRR). Dr. Suter reported that although the ACCME was sympathetic to the Executive Council's objections, a majority felt it was unfeasible to retain the authority for all final decisions at the ACCME. However, the ACCME did move to strengthen its position by requiring that two ACCME members be selected from nominations made by the ACCME member organizations to serve on the CRR. The ACCME members would monitor the activities and decisions of the CRR and report back to the ACCME.

On motion, seconded, and carried, the Board moved to approve the protocol as revised.

D. Issues Related to Appointment to PGY-2

At its June 30, 1983 meeting, the Board endorsed the staff's recommended plan of action for dealing with PGY-2 match issues. The plan included: (1) continued discussion with involved parties regarding the nature and scope of the problem; (2) an analytic summary of the responses to Dr. Cooper's letter to chairmen of the societies; (3) a problem list and mechanisms for addressing the problems including consideration of incentives for compliance and sanctions for noncompliance, and (4) a set of recommendations that could be endorsed by the AAMC, NRMP and the program directors representing the troublesome specialties.

Also provided was a summary of the responses from chairmen of specialty societies to Dr. Cooper's letters: The President of the Association of University Professors of Ophthalmology expressed a

high level of confidence with their own match program; the Association of University Professors of Neurology is now in the process of studying the issue. It has also distributed a detailed questionnaire to all program directors and residents involved in programs to July, 1983, querying their reactions to the match process including the Colenbrander program. The President of Otolaryngologists endorsed the separate ENT match and reported no intention to return to the NRMP; the Chairmen of Psychiatry reported that his association urges its members to work within the NRMP as much as possible, notwithstanding the fact that some are unhappy with the plan; the radiologists believe that their own system is working reasonably well and they have no plans to change; the Association of Orthopaedic Chairmen admits that their approach to the match is in some disarray and plans an indepth discussion of the system at its fall meeting; Chairmen of Pathology are concerned about the "widespread habit of making commitments to prospective applicants prior to the NRMP match" and will discuss the issue at its July meeting; the Chairmen of Pediatrics and Family Medicine regarded the match as a non-problem; Chairmen of Surgery identified lack of communication between the various specialties in medicine and the intense competition for the best students as problems deserving attention at their next meeting; the Chairmen of Thoracic Surgery regard the selection process as "something of a free-for-all" and have asked a member of the society executive council to survey the attitudes of the members and to initiate a discussion at their next meeting; the Professors of OB/GYN have no official statement; and the Chairmen of Medicine did not respond.

Dr. Cooper reported the intention of the NRMP: (1) to continue the traditional PGY-1 match; (2) to re-establish the "S" programs for program directors who want to appoint seniors for their PGY-2 year; (3) to permit students to rank order all programs in a specialty regardless of whether they are categorical or "S" programs; and (4) to make advance resident specialty matches ("R") available for programs that wish to offer positions to residents or other physician candidates, with dates of these matches arranged according to the wishes of the program directors. Dr. Cooper explained that the "S" program matches students for both their PGY-1 and PGY-2 choices for those programs which require that students take their first year after graduation outside of the specialty. The "R" program is designed for residents or returning practicing physicians who want additional training. Dr. Cooper stated his conclusion that these programs covered all matching needs.

Dr. Cooper reported that the NRMP Board did not want to assume responsibility for policing the match; consequently, it had been left to the AAMC to do what we could. He also reported that the release of result books had gone smoothly last year and felt confident that the deans would continue to honor their responsibility for the process. Dr. Cooper stated that Dr. Graettinger would like to extend the role of the deans in distributing result books to include the distribution of the books to nearby teaching hospitals. The Board endorsed the proposal that

the deans be asked to distribute the result books to those hospitals in close proximity.

Additional action steps were discussed. Two recommendations were made: (1) that the NRMP establish an advisory Panel consisting of a representative of each of the specialties offering an approved residency program; (2) that the AAMC Executive Committee invite representatives of Dermatology, Neurology, Neurosurgery, Ophthalmology, and Otolaryngology to meet with them in addition to representatives from the OSR and GSA.

#### F. Principles for Support of Biomedical Research

Dr. Sherman reported that the paper presented to the Board was the penultimate draft of the Association's statement of principles for the support of biomedical research. Two papers were developed by the staff and presented to the Board for its review at the June meeting. At that time, the Board recommended that the staff synthesize the issues presented into a single strategy paper. A new draft was considered by a review committee in August. Dr. Sherman reported that the only change made since that time was the recommendation that the NIH establish a process by which special interest groups would have the opportunity to present, to some formal body, their case for greater support and visibility, and that such presentations with subsequent analysis, be incorporated in the NIH decision making process to assure official cognizant of these views at the highest levels of government.

On motion, seconded, and carried, the Board approved the statement of the principles leaving the staff the latitude to incorporate changes made by the Board.

Dr. Kennedy introduced a second document to be submitted by October 1, 1983 to the Institute of Medicine. This paper set out a proposed AAMC position on the organizational structure of the NIH. He reported that the staff proposed that the document, "Principles for the Support of Biomedical Research" together with supplementary material based on this outline, would form the AAMC position paper to the IOM.

Although the AAMC would recommend that the current structure of the NIH be retained, the position paper introduced several concepts as contributions to the deliberations: that some explicit limitations be placed on the number of operating units with the NIH; that the NIH be required to reconsider its organizational structure every ten years; and that the NIH establish a formal, highly visible forum in which advocates of programs be encouraged to present their views.

Dr. Kennedy reported that the Association strategy was to attempt to shift the arena away from Congressional intervention in the scientific priority setting process and move it back into the executive agency guided by scientific advisors.

On motion, seconded, and carried, the Board endorsed the concepts embodied in the paper and recommended that an additional recommendation be included: that the IOM Committee enlarge the preview of its study to consider the optimal relationship between government and science, particularly, as far as Congressional intervention is concerned.

## V. Discussion Items

### A. Commercial Support of CME

In a recent communication to Dr. Cooper, Richard S. Wilbur, Secretary of the ACCME, expressed concern that some medical schools may inappropriately co-sponsor CME activities supported by pharmaceutical companies and/or equipment manufacturers. He included in his communication two policy statements regarding the relationship of accredited CME sponsors and commercial companies. On behalf of the ACCME, Dr. Wilbur requested that the AAMC Executive Council Review these statements and consider developing an AAMC policy statement.

It was the consensus of the Board that it was inappropriate for the AAMC to involve itself in the establishment of institutional policy on this matter. If there were violations of accreditation standards it should be handled as a matter between the ACCME and the institution. The Board recommended that a memo be sent to all deans, identifying the issues and attaching the two policy statements for their review and consideration.

### B. AAMC Regional Boundary Changes

Mr. Keyes reported that the Association is currently divided into four regions with an unequal number of institutions within each. This has some significance for the nominating process. Although the AAMC bylaws does not require equal representation from each region, the dynamics of the nominating process seems to work in that direction. After this matter had been included in the agenda, we were alerted to the significance of these geographic boundaries in AAMC time series data reports (e.g., housestaff stipend reports, and faculty salary studies).

It was the consensus of the Board that since there was no urgency for making any change and since any issues regarding nominations or elections could be adequately handled in their own right, the boundaries should not be tampered with at this time.

### C. Medical Center Officials and the AAMC

Occasionally, the Association receives communication from individuals in the academic health center who would like to be more involved in the AAMC activities. The staff expressed some concern that in many academic medical centers, individuals other than the dean and the hospital administrator are acquiring substantial

authority and responsibility for decisions impacting on medical education. If there is a power shift, the Association should consider how this impacts on its membership and its own position as spokesman for academic medicine. Although the topic will be discussed at the December Officers Retreat, the staff wished to elicit comments from the Board.

A brief discussion ensued in which Board members suggested that these individuals who wished additional information could attend the Association's Annual Meeting and be put on mailing lists, but that nothing should be done to alter the present AAMC structure with new membership categories.

#### D. Enrollment of Students in Summer Courses

Dr. Luginbuhl suggested that the AAMC consider the issue of member medical schools enrolling students from foreign medical schools in summer courses and to collect data on current practices. The Division of Student Programs made some inquiries and reported that 20 U.S. medical schools offered summer make-up courses. Only one school (Vermont) had a policy that participating students must be enrolled in an accredited U.S., Puerto Rican or Canadian medical school. Of the twelve course directors contacted as to the inquiries received from foreign medical students regarding their summer courses, no one reported more than 5 students had contacted them.

After a brief discussion, the Board determined that there was no need for any AAMC action with respect to foreign medical students in attending summer classes in U.S. medical schools.

#### E. Evaluation of the Status of the Management of Student Financial Assistance at Selected U.S. Medical Schools

At its June meeting, the Board considered a request for advice regarding the need for a series of workshops to improve the administration of student financial assistance to medical students. The Board members were unconvinced that such workshops were necessary and suggested that they query their financial aid officers at their own institutions and report their findings to the Board.

After a brief discussion, it was the concensus of the group that such workshops were not a profitable activity for the AAMC to conduct.

### VI. OSR Report

Pamelyn Close reported that the keynote address for the OSR Annual Meeting session was entitled, "Ethical Considerations for Medical Students: Questions that Nobody Asks." She also announced that the next OSR Report would highlight issues related to computers in medical education, NRMP and social responsibility, and nuclear war. She also reported that with the assistance of Dr. Kennedy, the OSR

has prepared packets of information to help prepare students in their discussions with their legislators.

## VII. New Business

### A. Recent Action on Medical Education Financing By The Advisory Council on Social Security

Dr. Knapp reported that at its August 24 meeting, the Advisory Council on Social Security adopted a resolution calling for a three-year study of medical education financing as the first step in an "orderly withdrawal of medicare funds from training support." The Advisory Council's rationale was that it is inappropriate for medicare to underwrite medical education costs when its prime purpose is to pay for medical services for the elderly.

Dr. Knapp asked the Board to review the staff's recommended action: to work to have the Advisory Council reconsider its resolution; to seek a revised resolution which recommends a study of alternative means of financing medical education and suggest that the findings of the study be used by future Advisory Councils to debate the reasonableness of terminating medicare support for medical education.

The Board endorsed this approach.

## VIII. Adjournment

The meeting was adjourned at 1:00 pm.

INFORMATION ON MEDICAL SCHOOLS' PATENT POLICIES,  
SMALL BUSINESS, AND ENTREPRENEURIAL INVOLVEMENT

Georgetown University has asked that the AAMC collect data on administrative arrangements and experience of member schools concerning: patent policies; faculty and staff involvement in independent small business concerns; and institutional conflict of interest policy. It has also offered to assist us in the review and compilation of the responses.

The staff believes this to be a useful project. Does the Board have any objections to our proceeding with this by way of a memorandum along the lines of the attached?

D R A F T

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

M E M O R A N D U M

To: Council of Deans  
From: John A.D. Cooper, M.D., President  
Subject: INFORMATION ON MEDICAL SCHOOLS' PATENT POLICIES,  
SMALL BUSINESS, AND ENTREPRENEURIAL INVOLVEMENT

AAMC members have requested the Association to develop comprehensive information on medical school (or where applicable, parent university) administrative arrangements and experience concerning:

Patent policies controlling inventions derived from federally funded research.

Institution, faculty and staff involvement in creation of independently owned and operated small business concerns designed for participation in the Small Business Innovation Research Program.

Involvement of institution faculty and staff as employees, officers, partners, shareholders, or owners of enterprises with or having the potential for conflict with the school's objectives or policies.



Council of Deans  
Page Two

For many institutions, administrative regulations concerning the above areas are detailed in faculty and staff handbooks or other directives.

We would appreciate receiving a copy of the pertinent documents, and a brief review of your school's experiences with patented inventions, the small business program and the school's contract entrepreneurial activities and those of faculty and staff.

Please send the information to Joseph A. Keyes, Director, Department of Institutional Development. Assistance in our review and compilation of the data will be provided by staff of the Georgetown University School of Medicine.

Status of Research Facilities and Instrumentation

Background. The continuing deterioration in the quality of research facilities and instrumentation in the academic laboratories, including those in medical centers, has become a matter of increasing concern to scientists, institution officials, and those science-oriented agencies within the Federal government responsible for science programs. A major constraint to prompt and sound planning to contend with this problem has been the absence of timely information as to the quantitative and qualitative dimensions of these research resources.

At the time of the June 1981 Executive Council meeting, the decision was made to establish an ad hoc committee to examine issues relating to the funding of research resources. This was prompted by a number of considerations, including concerns about the quality and quantity of instrumentation in academic institutions, increasing competition for available funds, and some uncertainty with respect to the future within NIH of the Division of Research Resources. No meeting of that committee was ever convened, in part because the threat to the continuing existence of DRR disappeared, and because it seemed that more comprehensive examination of these issues would be undertaken by organizations with a broader base than the Association.

Since that time, the concerns about the underlying problem have continued to grow, and several studies have been initiated or proposed in the two areas. They are summarized as follows.

(1) National Survey of Academic Research Instruments and Instrumentation Needs. Sponsored and supported by the National Science Foundation and NIH, and conducted by WESTAT, Inc., the purpose is to "provide a factual basis for the review of Federal equipment funding levels and priorities. This survey will document for the first time: (a) trends in the amount, condition and cost of existing research instrumentation in the nation's principal research universities and medical schools, and (b) the nature and extent of the need for upgraded or expanded research instrumentation in the major fields of academic science and engineering." The study involves a nationally representative sample of 43 major R&D universities and a partially linked sample of 24 medical schools. Information will be collected on a representative sample about each type of research instrument's age, cost, means of acquisition, condition and so forth. The findings will be used to develop quantitative indicators of trends over time and differences among fields in instrumentation costs, investment, condition, and need. The study will be conducted over a two-year period that commenced late in 1982. Medical schools will be involved only in 1983-84.

(2) A Project to Assess and Disseminate Alternative Approaches to Meeting University Research Equipment Needs. Originally supported

by NSF, DOA, DOD, DOE and NASA and carried out by AAU, NASULGC and COGR, this is a 16-month project, with the objective of "increasing awareness among research universities of opportunities for better planning and management of research equipment at all levels." The project is planned in three phases. In phase I, six analyses will be conducted to:

- Assess the role of debt-financing of research equipment and sound university financial practice;
- Identify and evaluate opportunities to improve the procurement, management, use, operation and maintenance of research equipment;
- Assess present tax incentives for the donation of research equipment and suggest ways to increase support from the private sector;
- Identify opportunities to eliminate or reduce state and university budget and policy barriers;
- Identify opportunities for changes in Federal regulations;
- Evaluate present methods of direct Federal investment and suggest improvements.

Phase II involves regional seminars to disseminate and discuss the results of the six analyses within the university community. The third phase is a briefing in Washington to present to Federal agencies and Congress the results of these analyses.

Apparently during the planning phase there was some confusion about the possibility of NIH also being a supporter of the project. As a consequence, there was no specific biomedical aspect to the study. Because of that, AAMC staff expressed their concern about this seemingly unnecessary and serious defect. Negotiations were therefore reopened with NIH, with the result that partial funding for part of the project to add a biomedical component has been assured. The project is to be completed in February 1985.

(3) Interagency Study of Academic Science and Engineering Laboratory Facilities. The House version of the Authorization bill for the Department of Defense for FY 1984 included the following provision: "The Committee also directs that a study be undertaken by the Secretary of Defense on the need to modernize university science laboratories essential to long-term national security needs. The study should be submitted to the Committee by March 15, 1984." The Congress also directed NSF to be a lead agency in encouraging other Federal agencies, state and local governments, and the private sector to support renewal of university research facilities. A steering committee was formed with representatives

from NSF, DOD, NIH and DOE to plan a study of such facilities. The objective is to obtain an understanding of the condition of university facilities currently being used for science and engineering research and the estimated future needs for construction, remodeling and refurbishment.

A request has just been directed to the chief executives of approximately 25 institutions asking for 5-year facility plans and estimated expenditures for new construction and remodeling of existing structures over that period. The purpose of this request is to assist the steering committee in its planning of the study and the preparation of an interim response to the Congress.

No further details are available at the moment, except for the expectation that most research-intensive universities will be included in the final survey population. AAMC has urged that the planning for the study be certain to include recognition of the unusual circumstances of teaching hospitals with sizeable research programs.

#### (4) Legislative Incentives.

• S. 1537. Senators Danforth and Eagleton introduced S. 1537 last year, a bill which provides additional authorizations for appropriations for FY 1984 and each of the four following years with the goals of (1) strengthening support for fundamental research in science and engineering, (2) upgrading, modernizing and replacing university research equipment, (3) providing increased numbers of graduate fellowships, (4) supporting faculty career initiation awards, (5) supporting efforts to rehabilitate, replace or improve university research facilities, and (6) supporting modernization and improvement of undergraduate science education.

The authorized sums are specified for DOA, DOD, DOE, NASA and NSF, whereas for NIH the bill states "... those additional amounts necessary to restore the capacity of NIH to conduct and support adequate levels of biomedical research." The yearly authorized sums for the other five agencies total \$139 million/year for acquisition, installation or modification of research instrumentation and \$245 million available on a matching basis for programs to modernize, rehabilitate, replace, or improve existing university research facilities.

The sponsors of the Senate Bill now plan to introduce this subject in the House. Since S. 1537 was not intended to pass as a separate Bill, but to express a sense of the Senate about the urgent need to support the Nation's university research capability and to influence the outcome of the Appropriations Bills, it is possible that

a Resolution will be introduced in the House and passage of a Joint Resolution sought.

The objectives of this legislative proposal are highly commendable, but insofar as biomedical research and the NIH are concerned, two difficulties remain to be resolved. The first is the complication of introducing the concept of an authorization ceiling for NIH at the very time when we are vigorously opposing that concept in legislation directed more specifically at the NIH. The second, more pertinent to the facilities and instrumentation issues, is that NIH no longer has broad constructive authority on which any program for major construction or renovation of facilities might have to be based.

● H.R. 2350. One of the provisions of the House bill to reauthorize parts of the NIH, H.R. 2350, requires a study "concerning the use of live animals in biomedical and behavioral research." One component of that proposed study reads as follows:

"Estimate:

(A) the amounts that would have to be expended by entities which conduct biomedical and behavioral research with Federal financial assistance to equip and modernize their research facilities in order to meet the standards referred to in paragraph (2); and

(B) The amounts that would be expended by entities which have not previously conducted such research with Federal financial assistance to establish, modernize, or equip facilities in order to meet such standards."

Other legislative initiatives have included the well-publicized efforts of several universities to obtain money for construction of research facilities through special-interest amendments in Congress. AAU, NAS, APS and AAAS have published statements strongly critical of that tactic, which bypasses the peer review processes of the scientific community and prospective funding agency.

(5) Current Mechanism for Funding Capital Improvements. Under OMB Circular A-21 it is possible to include depreciation or user charges for space and interest charges on money borrowed for major capital improvements in the indirect cost pool. The extent to which this mechanism is presently being employed is unknown.

Recommendations. The Association should:

1. urge its members to cooperate insofar as possible with any of the studies which are described above,
2. delay any further action as to additional surveys or other studies until the reports and analyses of the studies presently underway or pending are completed, and
3. monitor closely the progress and outcome of these studies.