New Directions for the IOM

Samuel Thier, newly appointed president of the Institute of Medicine, expects to make it a major health policy resource

In the late 1960's, a group of prominent medical researchers and physicians recognized a need in this country for an organization that could analyze the emerging and complex issues in health care with a breadth of expertise and position of neutrality that would lend stature and credibility to the enterprise. The product of their deliberations was the Institute of Medicine, chartered in 1970 as a semi-independent branch of the National Academy of Sciences.

During the past 15 years, the IOM has generated a number of significant studies that have affected legislation and health care. But it has also suffered difficult relations at times with the parent NAS and recently has been beset by financial stringencies that threatened its future. Many observers, therefore, view the Institute of Medicine today as an institution at a crossroads, needing for its long-term strength to demonstrate in the next few years that it can live up to its potential.

Last month, the IOM inaugurated Samuel O. Thier as its fifth president. Thier comes to the institute from Yale University School of Medicine where he has been chairman of internal medicine for more than 10 years. "I don't think the Institute of Medicine is used as much as it could be," says Thier, who hopes to see the IOM take more initiative in the future in terms of the work that it does. "The focus of the IOM," he says, "should be on the most important health-related issues that are amenable to study."

For instance, there are the problems raised by the changing face of health care delivery. Thier refers, for example, to an increase in the power and influence of for-profit medical care organizations. The companies will continue to own hospitals and are also beginning to diversify, offering their own health insurance plans and owning health maintenance organizations, he notes. And as these medical care networks spread, more and more physicians will be employed by them or will enter large group practices. "The autonomous, free-standing physician is probably an endangered species," Thier remarks.

As the business of medicine comes more and more in the hands of for-profit organizations, it will be more and more important to ensure that medical practice is driven by desires to provide quality care and to ensure equal access to care. The Institute of Medicine should take the lead in deliberating issues involving quality care and basic principles of access to medical care, says Thier.

Another major change on the horizon is that there soon will be a surplus of physicians. Thier envisions two possible consequences. Physicians will be paid less but will be more efficient and accessible in the more competitive marketplace. Or many will become more entrepreneurial, doing more tests and procedures to maintain what they view as the standard of living to which they feel entitled. The IOM should study and examine the impact of the imminent physician surplus, according to Thier, and should also consider what to do if it is decided that fewer doctors should be trained. "If you decide that the number of doctors should be cut by 20 percent, what do you do?" he asks. "Do you cut each school by 20 percent or do you close 20 percent of the schools? Medical schools vary in the intensity of training they give, but it's an emblem for a state to have a medical school and it's very hard to close it. But you lose tuition money if you cut students, which can make it hard to keep faculty."

Samuel Thier

The new IOM president hopes to develop long-term support and mobilize the institute's members.

We also are living in a time when funds for medical research are unpredictable. The IOM should analyze the problems that arise from unstable support for medical research, without waiting to be asked, Thier says.

And, of course, the practice of medicine is bound to be altered by the advances in basic research. Gene therapy, artificial organs, increasingly successful organ transplants, and developments in the neurosciences that are important in understanding behavior give rise to scientific, philosophical, ethical, and legal questions. The IOM, according to Thier, is a place "where people can talk coolly and calmly."

The 650 members of the IOM, who represent not only medicine and research but also hospital administration, ethics, nursing, and law, among other fields, have together "a significant breadth of expertise. It is unlike virtually any other organization," says Thier. But the institute is not used effectively enough, in Thier's opinion, and he would like to see it build a strong endowment for long-term support to allow it to set its own agenda. Several foundations have promised renewed support and Thier hopes to be successful in raising support from health-related enterprises such as the pharmaceutical industry, insurance companies, and for-profit hospital corporations.

Thier also would like to see the IOM studies completed more promptly—the average study now takes 18 months—which should save money and also provide quicker answers to those who sponsor the studies. "Advice may be of little use if delivered 18 months to 2 years after it is requested," he remarks. "A goal of cutting the time of our studies in at least half would seem reasonable."

The long-term support that Thier hopes to get should enable the institute to set its own agenda and to grapple with problems that do not go away, those that cannot be handled in a year-long study. These include questions of health technology assessment, health care financing, and drug development. "At the moment, there is no place where people with varying expectations can sit down and talk to each other," Thier says. "We should convene, at regular intervals, groups for the long-term consideration of ever-present problems such as drug development and regulation, health technology assessment, or health care financing." A useful format might be the development of a forum in which repre-

sentatives of different perspectives and expectations meet in an ongoing discussion, spinning off selected issues for study and advice, while maintaining a long-range overview of their changing fields." The result of these meetings might be that smaller, more manageable problems may be defined for further study and, just as important, the members of the group would come to understand each other's points of view.

Going along with the ability to set its own agenda, the IOM should make itself more visible so that government organizations will automatically turn to it for timely advice and so that its reports that are of interest to the public are also readily available. He would like to see increased rewriting of reports that are of interest to the public and increased use of television and, possibly, even regional public meetings at which IOM members discuss topics of great interest to the public.

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In addition to serving as department chairman at Yale medical school, Thier also has been chief of medical services at Yale–New Haven Hospital. At Yale, he worked to improve the training of clinical researchers and developed a statewide network of affiliated hospitals to provide continuing education for internists. He has been president of the American Federation for Clinical Research, a member of the NIH director's advisory committee, a member of the editorial board of the *New England Journal of Medicine*, a regent of the American College of Physicians, and chairman of the American Board of Internal Medicine. His research interest is inherited diseases of renal function. Thier succeeds Frederick C. Robbins, who will return to Case Western Reserve University School of Medicine.

Thier sees his role as IOM president as one of seeking long-term support, critically assessing proposed studies, and mobilizing the institute's members. "I am concerned that the IOM not do things that are so broad as to be meaningless nor that are well-focused but trivial. How to get between the two points is the problem," he says. "If the IOM fulfills its role," he concludes,"it could be a major resource."—**GINA KOLATA**

Congress Passes NIH Bill

After struggling for several years with legislation for the National Institutes of Health, Congress for a second time agreed to a reauthorization bill for the NIH that sets forth important policy. But whether President Reagan will sign the bill once it arrives on his desk is a matter of speculation, even though certain provisions were crafted with an eye toward getting the President's signature. For instance, the bill provides for the establishment of a new institute for arthritis research—the National Institute of Arthritis and Musculoskeletal and Skin Diseases, as did a similar bill last year that received a pocket veto from President Reagan (*Science,* 16 November 1984, p. 811).

Significantly, however, unlike last year's bill, the current legislation does not contain provisions for a new nursing institute. Reagan's veto rested in part on his position that a nursing institute was too costly and unnecessary an addition to the NIH. Although the institute was a feature of the House bill again this round, during House-Senate conference House backers compromised on a provision to establish a National Center for Nursing Research within the NIH. "The Center is intended to provide a focal point for promoting the growth and quality of research related to nursing and patient care," the conferees said. It will have its own director.

On another point that required House-Senate compromise, the House agreed to go along with the Senate's decision to reauthorize the cancer and heart institutes for another 3 years instead of just one. The opportunities for congressional micromanagement of the institutes that is implied in single-year reauthorization has been a bone of contention all along.

The new bill does speak to the management of NIH on a number of points, however. For instance, it requires the NIH director to establish procedures for the periodic review of the institute's intramural research programs, although it specifically states that the internal peer review need not follow the format for review of outside grant and contract applications. Intramural peer review might consider the work of an entire laboratory rather than that of the principal investigator. The bill also mandates the appointment of an associate director for disease prevention in the NIH director's office and the child health and cancer institutes.

Arguments about whether the special privileges of the National Cancer Institute should be continued came out in favor of the NCI as it stands. The congressional conferees note that "The special authorities that have enabled the NCI to become one of the most productive of the national research institutes have been retained in their entirety." These include the National Cancer Panel, which reports directly to the President, and a provision that allows NCI to submit its budget requests directly to Congress, rather than going through the Administration.

Responding to instances of scientific fraud that have occurred during the past few years, the House and Senate included requirements that NIH establish formal, prompt review procedures for handling allegations of misconduct, citing the fact that its ad hoc methods have resulted in reviews taking more than a year even when the fraud was admitted. Congress also added a requirement that NIH grantees have in place an administrative process to investigate reports of scientific fraud and to alert NIH to any allegations that appear to be substantial.

Another provision of interest is one creating a Congressional Biomedical Ethics Board, patterned after the bipartisan Office of Technology Assessment which conducts studies in response to congressional inquiry. The legislation mandates two special studies for the new board: an examination of the issues involved in permitting the Secretary of Health and Human Services to grant a waiver of current fetal research guidelines in selected cases and a study of the ethical issues in human genetic engineering—a subject the Office of Technology Assessment has reviewed in some detail.

In addition, the bill mandates the creation of boards or committees to look at a number of special medical problems, including spinal cord injury, learning disabilities, lupus erythematosus, Alzheimer's disease, and future personnel for the health needs of the elderly. —**BARBARA J. CULLITON**