

Association of American Medical Colleges  
Annual Meeting  
and  
Annual Report  
1978



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## The Chairman Looks at the AAMC

*Robert G. Petersdorf, M.D.*

It has become customary for the chairman of this organization to deliver himself of an address to this semicaptive audience, semicaptive because it has usually been left too numb by the previous speaker—generally a government functionary—who either has berated it for failing to meet an important challenge, such as admitting to medical school any student who wishes to go, despite the fact that there is no need for him or her, or has exhorted it to accomplish a task that is quite impossible, such as delivering better care to more people at 1975 prices. At the very least, the hapless chairman is expected to soothe the pain, usually by relying on the old standbys, quality, stability, and excellence, a form of verbal balm which has little meaning in today's health scene.

Indeed, I had a good deal of difficulty in finding a theme for this talk. In the past, I have used similar platforms to take semihumorous looks at such academic phenomena as departmental chairmen or recruiting practices. But there is little to laugh about these days. As the patient said when he was informed on awaking from anesthesia that a sponge had been left in his abdomen, it hurts too much to laugh.

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This paper was delivered at the October 24, 1978, plenary session of the Annual Meeting of the Association of American Medical Colleges, New Orleans, Louisiana.

Dr. Petersdorf, professor and chairman, Department of Medicine, University of Washington School of Medicine, was the 1977-78 chairman of the AAMC.

I then tried to find some inspiration in the addresses of former chairmen of the Association, and a distinguished group they are. But how could I, a little old department chairman, try to equal the ennobling thoughts of these gentlemen, all of whom are deans or presidents of medical centers (Figure 1). Moreover, the verbal pyrotechnics of Ivan Bennett, the steely analysis of the issues that divide the academic world and government delivered by Leonard Cronkhite, the careful review of health programs presented by Charlie Sprague, the biblical sagacity of Sherman Mellinkoff, and the uplifting rhetoric, liberally punctuated by quotations from Thomas Jefferson we heard from Dan Tosteson can have no equal. Besides, they said everything I wanted to say.

Rather than discourse on one or several of the weighty issues with which we are all familiar—cost containment, financing of medical education, health manpower, or support of biomedical research—I want to spend a few minutes talking to you about our organization, the AAMC. I do this, in part, because this organization is subject to a lot of criticism; some perceive it as doing too little too slowly, and others think of it as doing too much too fast. Some think of it as an action-oriented political lobby, while others see it as an academic debating society contemplating its collective navel. Some might define it as a herd of bulls, the deans, chasing their cows, the federal buck, in totally uncoordinated fashion, while others conceive of it as a



FIGURE 1

The past recent chairmen of the Association of American Medical Colleges are, from left, Dr. Ivan L. Bennett, Jr., Dr. Leonard W. Cronkhite, Jr., Dr. Sherman M. Mellinkoff, Dr. Daniel C. Tosteson, and Dr. Charles C. Sprague.

group of sheep led by a firm, and hopefully wise, shepherd, John Cooper. Few who talk about the AAMC, either in laudatory or critical terms, know much about it, and I thought that it might not be amiss to leave you with a few impressions of this organization—gleaned from the top, so to speak—and to tell you what we do well, what we do poorly, and, perhaps most importantly, what we might do better and how we might do it better.

The last time a chairman dealt with the problems and progress of the AAMC was at the 1972 meeting in Miami when Russell Nelson reviewed the issues that confronted the Association at that time. They included institutional responsibility for graduate medical education; the staffing and modus operandi of the LCGME and the LCCME, which had just been conceived, but both of which have suffered from growth arrest; the Association's relationships with other organizations; and, of course, its intercourse with government. At that time, Dr. Nelson focused on HMOs and national health insurance as the issues most likely to affect the educational establishment. These may still come to pass, but it is perhaps most noteworthy that the problems with which the Association was grappling in 1972 have not been resolved and are still in full bloom in 1978.

This recounting of history is valuable, I think, to make three points. The first is

that patience is a virtue. The wheels of progress—and I use the term euphemistically—in the health business grind slowly and often imperceptibly, a point which should not be lost on our policymakers. Secondly, although it may not seem so to the officers of the Association, who are all too often engaged in crisis-oriented conference calls, the major issues which an organization like the AAMC must address require a long-range view and transcend the terms of the elected chairman and, indeed, in some instances the three- to six-year terms of the members of the Executive Council. And, thirdly, continuous attention to these long-range issues requires a staff of permanency, skill, and dedication. We are blessed by having such a staff at the Association.

While many of the recent issues confronting the AAMC may seem like perennial bloomers, in point of fact that AAMC is a young organization, if not chronologically at least functionally. Although the Association celebrated its 100th birthday in 1976, a fact which along with my 50th birthday was lost in the nation's bicentennial, and appropriately so, it really came of age only in 1965 when, as a result of the Coggeshall report, it was decided to transform it from a corner grocery in Evanston, Illinois, that could barely meet its payroll to a modern department store in Washington, D.C. (Figure 2) which

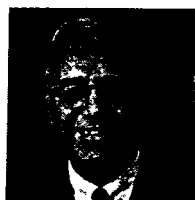
opened its doors for business in 1970. More importantly, the AAMC changed conceptually from a "dean's club" to an organization that is representative of all of academic medicine. Lest you think that I use the term dean's club pejoratively, the 1940 meeting was called exactly that.

The spectacular progress of the Association, particularly in espousing the causes of the academic community in Washington, is a matter of record; and, indeed, the recognition of John Cooper, our leader, as the nation's third or fourth most powerful individual—after Senator Kennedy, Representative Rogers, and perhaps Secretary Califano—in health matters attests to our rapid growth and increasing influence. I need not detail the multiple services like AMCAS, AMCAT, the faculty roster, or data on house staff and faculty salaries that the Association offers.

With its rapid growth, the AAMC has become an increasingly complex organization. This is largely a reflection of the conscious decision made a decade ago to have the AAMC represent the medical schools not only through their deans but also through their teaching hospitals in the form of the Council of Teaching Hospitals, their faculties through the Council of Academic Societies, and their students in the form of the Organization of Student Representatives. This has made the constituency of the AAMC extraordinarily large and diverse and its governance unusually complex. Figures 3 and 4 depict an organizational chart of the AAMC as viewed by the staff and, in more surrealistic terms, by me. Even within its quadricameral structure, there is little homogeneity. For example, within the Council of Deans, there are representatives of private schools and state schools, and the interests of newly developing schools are represented along with those of more traditional institutions. And while some of the teaching



Dr. Cooper



Dr. Nelson

hospitals are university-owned, more are private institutions governed by boards which are not the regents or trustees of the university. Some hospitals are government institutions, and others are church-affiliated; some are closely affiliated with the university while others have relatively distant connections. Among the academic societies, some consist of basic scientists and others of clinical specialists; and a third group comprises largely organizations of department chairmen. These three constituencies within the CAS have very different agendas; moreover, the cause of unanimity is not helped by the fact that most academic societies elect a new slate of officers annually, making any sense of continuity difficult if not impossible.

It should not be surprising that an organization as large and heterogeneous as the AAMC would have difficulty arriving at a common point of view on major issues, and therein lies one of our problems. We sometimes have had difficulty in speaking out clearly in unison on some major issues. Sometimes, these internal political conflicts can be kept "inter familias" and permit the Association to present a solid front. This was the case in the Association's unrelenting opposition to HR 2222, which would permit unionization of house staff under the NLRB. In this instance, the OSR voted to support the bill but was simply outvoted by a large majority of the other constituents on the Executive Council.

In another instance, however, that of the manpower legislation that mandated the

transfer of USFMGs to American medical schools in order for the schools to qualify for capitation, the AAMC's initial position was much more equivocating. While deep in his heart everyone felt that the law was wrong and that the government had no business in the medical school admissions process, the Association did not issue a clarion call of outright opposition to the implementation of the legislation for several reasons. First, a number of schools could not have survived financially without capitation support; secondly, some state schools felt that rejection of capitation would lead to retaliation by their own legislatures, which were under pressure to pass similar laws; and, finally, there was some hesitation on the part of some in the AAMC to offend the sponsors of the bill who had done so much for the benefit of medical education. The AAMC's position was, therefore, conceived in internal political conflict, and, as a result, was less explicit than it might have been.

In contrast, when the Association gets its act together and marshals its forces for a common purpose, it can achieve results that are nothing short of spectacular. A recent example was the concerted effort that was made to repeal Section 227 of the Social Security regulations that would se-

lectively reimburse some teaching hospitals on a cost, rather than a fee-for-service, basis. In an attempt to redress a few instances of alleged fraud, the proposed law would punish a large number of teaching hospitals for the presumed transgressions of a few. Moreover, the legislation would not serve its professed purpose; rather, it would impose a strict fiscal test on teaching hospitals which, in turn, would reintroduce separate care for public and private patients, the very distinction that the Medicare law was meant to obliterate. Led by a group of southern deans, the Association marshaled its constituency and within a few days nearly 30 senators had been persuaded to cosponsor an amendment for repeal. More importantly, the entire constituency got behind this effort, whether or not a particular institution or its hospitals would be affected adversely. Put differently, we forgot our diverse interests and worked for the common good. Although the final compromise will be a delay in implementation of Section 227, followed by appropriate revisions, this is an example of highly effective political action on the part of the AAMC achieved largely, I might say, by the extraordinary efforts of a number of individuals who worked in a common cause.

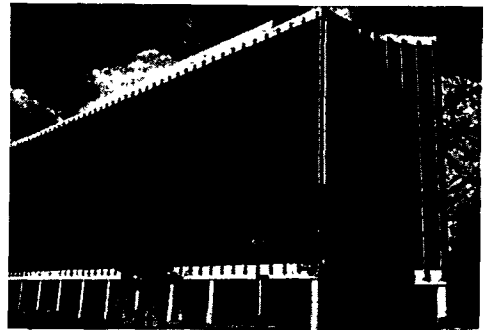


FIGURE 2

The AAMC's former headquarters in Evanston, Illinois, is shown at left. At right is the building in Washington, D.C., that includes the Association's present headquarters.



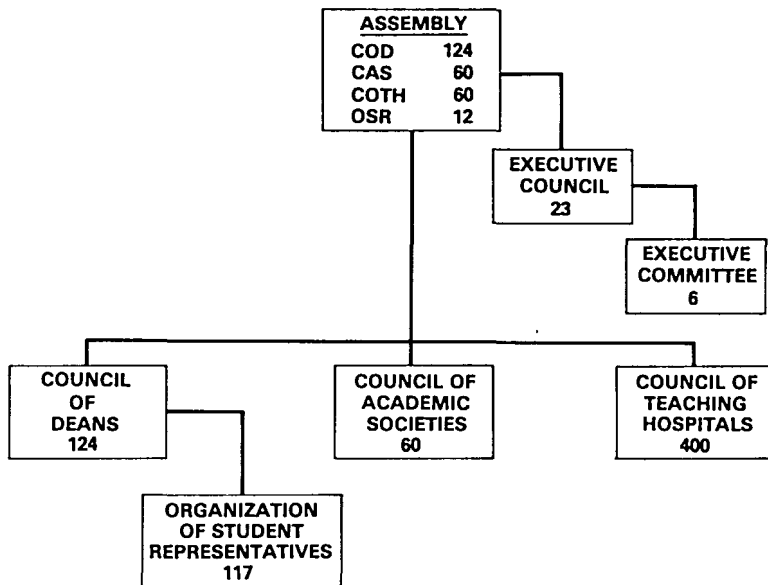


FIGURE 3  
Staff diagram of organizational structure of the Association of American Medical Colleges.

Because so many in Washington, including Congressional staff, members of the HEW bureaucracy, the NIH, and the OSTP, look to the AAMC for leadership on issues dealing with medical education, it is particularly important for the Association to arrive at clear positions and to factor internal political considerations out of the equation when formulating these positions. This is not always easy and, as long as the AAMC is as ecumenical an organization as it is, will be troublesome from time to time.

A more difficult situation arises when one or another of the many organizations concerned with health policy that seem to be springing up in Washington like weeds on a well fertilized lawn takes a position which is contrary to one assumed by the AAMC. Among the organizations dealing with health policy are scientific umbrella organizations such as FASEB; organizations which represent university presidents such as AAU, ACE or NASLGUC; organizations that represent other health

professional schools; the Association for Academic Health Centers; not to mention organizations, such as the AMA, that deal primarily with medical practice as well as education. I do not question the prerogative of these organizations to exist on the Washington scene; nor do I question their or their constituencies' legitimate interest in health issues. But I am concerned about their occasional tendency to becloud a clear-cut issue in smoke, fog, or both. And even a non-Californian knows that the smog is irritating. An example of this occurred in the recent Section 227 imbroglio when, irrespective of the steps that were in progress to repeal the statute, another organization took it upon itself to propose that the issue be negotiated without first obtaining more information about the extensive and prolonged history behind Section 227 or the AAMC's long involvement and expertise in it and without assessing the political consequences of its action. Although the problem was resolved, to put it in the vernacular, those folks nearly blew

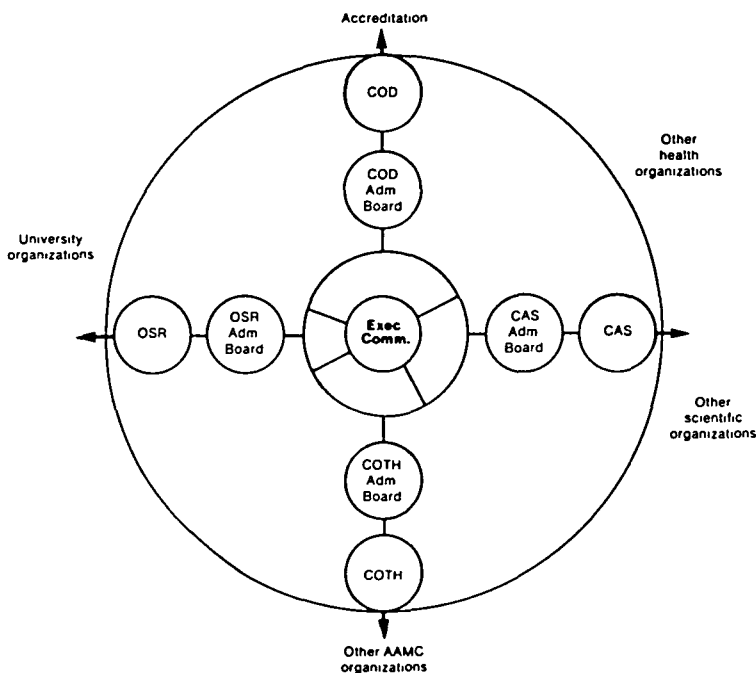


FIGURE 4

Author's concept of the organizational structure of the Association of American Medical Colleges.

it for us. More importantly, the whole business could have been avoided if that organization had communicated its concerns to the AAMC before striking out on its own.

This little diatribe should not be interpreted to mean that the AAMC should corner the market in all issues that deal with medical education or health care related to education. It does mean that those organizations that want to play in this ball park play as a team and not as individuals. It means that all organizations have to be sensitive to each others' concerns, and most of all it means that they have to inform one another, regularly and candidly. And it also means that from time to time, for the sake of reaching consensus, one organization must subject its interests to that of another. This applies to the AAMC as well as other organizations. Although we have sometimes been guilty of

being on center stage when we should have remained in the wings, we are more aware than most of the importance of presenting a unified front to those who make health policy. For example, in recent years our recommendations on the HEW budget have been made a part of those of the Coalition for Health Funding, a consortium of health agencies conceived with education. Similarly, our position on new regulations dealing with overhead for research, circular A-21, is being communicated through those organizations that deal with pan-university matters. This is as it should be; reimbursement of indirect costs is clearly a budgetary problem for the entire university and not only its medical school.

Finally, we are sometimes perceived as a self-serving special interest organization whose only agenda is the benefit of its members. Let me say here and now that

there is nothing inherently wrong in an organization representing the special interests of the medical schools. If we didn't, who would? Besides, the representation of special interests is very much part of our political process; in fact, the only individual in Washington who doesn't espouse a special interest is the ticket manager of the Washington Redskins; he doesn't need to, because he will sell out the house no matter what.

In the case of the AAMC, of course, our special interests must be tempered with the needs of the public, at least to the extent that these needs are perceived by the framers of public policy. And because we have to take the stand of acting in the public interest as well as our own, we are sometimes put in uncomfortable positions. I have no problem, for example, with our position expressing the need for federal subsidies for medical education because I feel, along with many of you, that our medical schools represent a national resource whose products benefit the entire country. But I have a good deal of trouble in championing capitation predicated on class size as the instrument with which to support the medical schools, when there is increasing evidence that there will be a surfeit of physicians within a decade, if there is not already, and that the remedy for this surfeit might actually be a decrease in class size. And I question whether it is appropriate to take a position against payback for biomedical research training when it is far from clear that this administrative device has deterred entry into research training in the first place, or whether it has kept the trainees in academe rather than having them pursue a lucrative career in a clinical specialty. And I wonder whether we can ever shed the stigma of "double dipping" as long as we insist on reimbursement of supervisory services by teaching physicians under Part A of the Medicare law while collecting fee-for-ser-

vice under Part B. Admittedly, in many instances these services are clearly separable and billing for both is entirely justifiable and follows the intent of the law. But, in some instances, the boundary between professional and supervisory services is blurred, and it is in these instances that we must take particular care to bill for one or the other but not both.

These examples have been cited as situations in which the Association may be perceived as having placed the welfare of one or the other of its constituencies ahead of the public interest. Clearly, such an interpretation is subject to argument and there are articulate champions for each position within the Association. My point is that we must go to extraordinary lengths to shed our more parochial instincts and to examine the impact of our actions on the public welfare. Only by following such a course can we maintain and enhance the Association's credibility in Washington.

Finally, effective though our Association is, how can we do better? First, by increasing the participation of our colleagues—deans, faculties, administrators, and students—in the affairs of the Association. I never cease to be amazed at the relatively few individuals who populate our conferences, committees, and task forces. I also never cease to be disappointed by those who refuse to serve because they are too busy or overcommitted, who resign from committees before the task is completed, or who quit *de facto*, if not *de jure*, by failing to show up for the meetings. Although the AAMC has a superb, dedicated, and knowledgeable staff, it is in essence a voluntary organization that derives many of its ideas and concepts, and eventually all of its policies, from its membership. If we care about the values that attracted us to academic medicine—the importance of excellent teaching and research, the training of

young people, and the practice of exemplary medicine—then we must become good academic citizens in much the same way that we must practice good citizenship to preserve the values in our society. We must become involved.

Secondly, we need to communicate with one another about the issues that concern us as academic citizens and that, as our citizens' lobby, concern the Association. This implies a greater commitment than perusing John Cooper's weekly reader, dazzling though his prose may be. It means informed discussion of the issues at faculty meetings, over laboratory benches, in the corridors and lunchrooms of our schools and hospitals, and even on ward rounds. The days when the majority of the academic establishment can remain sequestered in its ivory tower in splendid isolation from the world about it are gone forever. Academic medicine is very much in the public sector and demands a new and additional role of all of us—that of the informed, thoughtful academic citizen.

Lastly, let me come back to one point. We in academe are, whether we like it or not, very much in the public eye. Most of our wherewithal comes in one way or another from the taxpayer; most of our decisions affect not only our internal constituency, the faculty, and students but also a much larger one, our patients. And because we are in one way or another responsible for the education and training of those who will deliver health care in the future, we have been given an extraordinary public trust. An organization like the AAMC gives us, as individuals, the opportunity to serve the cause of academic medicine. We may not always agree with the positions it takes, the causes that it champions, or the means by which it achieves its ends. But it is more often right than wrong, more often responsible than derelict, and more often winner than loser. With its strong staff and the talent among its membership, it is by far the best game in town. It needs all of us—all of you—to make it even better.

# The Eighty-Ninth Annual Meeting

New Orleans Hilton Hotel, New Orleans, Louisiana, October 21-26, 1978

Theme: National Health Planning and Regulation: Implications for Medical Education

## Program Outlines

### PLENARY SESSION

**October 23**

Presiding: John A. Gronvall, M.D.

*Medical Care and the Universities*

John T. Dunlop

*Public Policy and the Medical Establishment:  
Who's on First?*

Victor R. Fuchs

*Regulation and Academic Medicine: The Quebec  
Experience*

Sidney S. Lee, M.D.

ALAN GREGG MEMORIAL LECTURE:

*On the Planning of Biomedical Science*

Lewis Thomas, M.D.

**October 24**

Presiding: Robert G. Petersdorf, M.D.

PRESENTATION OF BORDEN AND FLEXNER  
AWARDS

Honorable Joseph A. Califano, Jr.

Chairman's Address

Robert G. Petersdorf, M.D.

### COUNCIL OF ACADEMIC SOCIETIES

**October 23**

Business Meeting

Chairman: Robert M. Berne, M.D.

*The Teaching of Geriatric Medicine in U.S.  
Medical Schools*

Paul B. Beeson, M.D.

### COUNCIL OF DEANS

**October 23**

Business Meeting

Chairman: Julius R. Krevans, M.D.

### COUNCIL OF TEACHING HOSPITALS

**October 23**

Business Meeting

Presiding: David L. Everhart

General Session

Presiding: Robert M. Heyssel, M.D.

MULTIPLE HOSPITAL SYSTEMS AND THE TEACH-  
ING HOSPITAL

*The Opportunities*

Ed J. Connors

*The Problems*

Mark S. Levitan

### COD/CAS/COTH JOINT PROGRAM

**October 24**

THE INTERPLAY OF GOVERNMENTAL REGULA-  
TION, PROFESSIONAL RESPONSIBILITY AND MAR-  
KET FORCES IN THE FIELD OF HEALTH

Alan K. Palmer

Julius R. Krevans, M.D.

BIOMEDICAL RESEARCH AND THE PUBLIC INTER-  
EST: THE ROLE OF PUBLIC SECTOR REGULATION

Laura Nader, Ph.D.

Ivan L. Bennett, Jr.

### MINORITY AFFAIRS PROGRAM

**October 24**

MINORITIES IN MEDICINE: THE NEXT DECADE

Presiding: Dario O. Prieto

PRESENTATION OF NATIONAL MEDICAL FELLOW-  
SHIPS AWARDS

Franklin C. McLean Award

William and Charlotte Cadbury NMF Scholarship Award

NMF Scholarship Award for Scholastic Excellence

Introduction

John A. D. Cooper, M.D.

Keynote Address

Honorable Edward R. Roybal

## ORGANIZATION OF STUDENT REPRESENTATIVES

### October 21

Regional Meetings

Discussion Session:

*Introduction to the OSR and the AAMC*

Paul Scoles

Peter Shields

Discussion Sessions:

*A Career in Academic Medicine and Clinical Research—Let's Look at the Facts*

Richard Knazek, M.D.

Jay R. Shapiro, M.D.

Thomas E. Morgan, M.D.

Student Financial Aid

Robert J. Boerner

National Resident Matching Program

John S. Graettinger, M.D.

Business Meeting

### October 22

Discussion Sessions:

*National Resident Matching Program*

John S. Graettinger, M.D.

*Medical Students and Faculty: Research & Service Teaching*

Judith Swazey, Ph.D.

Women in Management

Judith B. Braslow

Doris A. Howell, M.D.

Molly Osborne, Ph.D.

Candidate for OSR Office Session

Business Meeting

Regional Meetings

MOLDING OF PHYSICIANS FOR THE 1980s: SELECTION, SOCIALIZATION, OR LEGISLATION?

Moderator: Eileen Shapiro

Selection Process

Daniel H. Funkenstein, M.D.

Professional Socialization During Medical School

Pearl Rosenberg, Ph.D.

Impact of Legislation

Fitzhugh Mullan, M.D.

A Theoretical Framework

Judith Swazey, Ph.D.

A Student's Perspective

Paul Scoles

### October 23

BECOMING A PHYSICIAN: INFLUENCES ON CAREER CHOICE

Session I

*Academic Physicians: An Endangered Species*

Marianne J. Legato, M.D.

Session II

*Mentors and Role Models in Medical Education*

Eileen Shapiro

Joan G. Stelling, Ph.D.

Samuel W. Bloom, M.D.

Session III

*Impact of the Federal Government on Careers in Academic Medicine and Research*

Leah M. Lowenstein, M.D.

David R. Challoner, M.D.

Ruth Hanft

Ruth L. Kirschstein, M.D.

## COST CONTAINMENT IN MEDICAL EDUCATION

### October 24

Moderator: Stanley M. Aronson, M.D.

Introduction

Stanley M. Aronson, M.D.

A REVIEW OF SELECTED COST CONTAINMENT PROGRAMS

Indiana University School of Medicine

Steven C. Beering, M.D.

Hospital of the University of Pennsylvania  
Sankey V. Williams, M.D.

Jackson Memorial Hospital  
Leon W. Zucker  
William I. Roth, M.D.

THE IMPLICATIONS OF COST CONTAINMENT: A  
CURRENT APPRAISAL AND EVALUATION  
John G. Freymann, M.D.

Questions and Discussion

#### ANNUAL FINANCIAL QUESTIONNAIRE WORKSHOP

**October 23**

#### FACULTY ROSTER WORKSHOP

**October 24**

#### WOMEN IN MEDICINE

**October 23**

MANAGEMENT ROLES FOR WOMEN IN ACADEMIC  
MEDICINE

Moderator: Judith B. Braslow

*Classic Managerial Theory: Its Modern Day  
Application*

Peter B. Vaill, Ph.D.

*How Women Respond in Managerial Positions*  
Caroline Bird

*Perspectives of Managing at the National Insti-  
tutes of Health*

Ruth L. Kirschstein, M.D.

*Managing the Academic Medical Center: The  
View of a Former Public Official*

Theodore Cooper, M.D.

Discussion

#### RESEARCH SYMPOSIUM

Chairperson: Nancy Roeske, M.D.

*The Specialty Preferences of Recent Women  
Medical School Graduates*

Janet Melei Cuca

*Graduate Medical Training in the School of  
Medicine at Yale University*

Sherry Penney, Ph.D.

*A Follow-up Study of Male and Female Medical  
School Graduates*

Carol Nadelson, M.D.

Malkah Notman, M.D.

*Women Medical Students: A New Appraisal*

Marilyn Heins, M.D.

Jane Thomas, Ph.D.

Discussion

#### GROUP ON BUSINESS AFFAIRS

**October 21**

Regional Meetings

**October 22**

Carroll Memorial Lecture

*"Institutional Responsibility (?) in 1978"*

Christopher C. Forham, III, M.D.

National Meeting

FINANCING GRADUATE MEDICAL EDUCATION:  
TEACHING PHYSICIAN FEES, HOUSE STAFF STI-  
PENDS AND THE COST OF SUPERVISION

Moderator: Richard G. Littlejohn

*Financing Graduate Medical Education: As I  
See It*

Mitchell T. Rabkin, M.D.

*House Staff Stipends and the Cost of Education:  
Medical School/Teaching Hospital Financial  
Relationships*

David D. Thompson, M.D.

*Professional Fee Income as it Relates to Financ-  
ing Graduate Medical Education*

Hiram C. Polk, Jr., M.D.

#### GROUP ON MEDICAL EDUCATION

**October 23**

Plenary Session

THE HOUSE OFFICER AS A TEACHER: PRIORITIES  
FOR UNDERGRADUATE AND GRADUATE MEDICAL  
EDUCATION

Moderator: George L. Baker, M.D.

*Formalizing Teaching Responsibilities for the  
House Officer*

Hugh M. Scott, M.D.

*How Teaching Complements and Enriches  
House Officer Education and Patient Care*

Fred Schiffman, M.D.

*What Schools Expect and Measure: The AAMC Clinical Evaluation Project*

Xenia Tonesk, Ph.D.

Reactor: David H. Solomon, M.D.

Regional Meetings

**October 24**

Special Sessions

CAN ACCREDITATION ASSURE QUALITY IN CONTINUING MEDICAL EDUCATION?

Moderator: Thomas C. Meyer, M.D.

LCCME

Julius Stolfi, M.D.

State

Leonard S. Stein, Ph.D.

AAMC

William D. Mayer, M.D.

CME Director

Frank R. Lemon, M.D.

PRA/Consumer

Ross L. Egger, M.D.

USE OF THE NATIONAL BOARDS FOR PROGRAM EVALUATION

Introduction

Frank T. Stritter, Ph.D.

*The Need for External Criterion*

Neal A. Vanselow, M.D.

*History and Current Policy of the NBME*

Edith J. Levit, M.D.

*A Case Study*

Gregory L. Trzebiatowski, Ph.D.

A Case Study

Frank T. Stritter, Ph.D.

TRANSITION PROBLEMS FROM UNDERGRADUATE TO GRADUATE MEDICAL EDUCATION: PRELIMINARY RECOMMENDATIONS FROM THE AAMC TASK FORCE

Moderator: D. Kay Clawson, M.D.

Chairman, Working Group on Transition

John S. Graettinger, M.D.

Special Staff Consultant to AAMC Task Force on Graduate Medical Education

Ann S. Peterson, M.D.

Member, Working Group on Transition

Kenneth W. Rowe, Jr., M.D.

A Program Director

**October 25**

Business Meeting

INTRODUCTION TO CLINICAL MEDICINE EDUCATIONAL EXHIBITS

*A Systematic Approach to Designing an ICM Course*

Robert L. Pace, M.D., et al.

*Approaches to the Evaluation of ICM*

Jerry R. May, Ph.D., et al.

*Teaching Chart Review at the Preclinical Level*

M. J. Peters, et al.

*The Problem List*

David M. Klachko, M.D.

*Learning Resources to Teach and Evaluate Problem-Solving Skills*

Howard S. Barrows, M.D., et al.

*Evaluation of Problem-Solving Skills*

John Corley, M.D.

*Teaching Examination and Problem-Solving Skills*

James C. Guckian, M.D., et al.

*Acquisition of Examining and Problem-Solving Skills*

Paul Cutler, M.D.

*Computer-Assisted Instruction—Simulation of Seminars in Problem-Solving*

Peter Tuteur, M.D.

*Comparison of Instructor, Checklist, and Videotape Feedback on Student Performance of Physical Examination*

William E. Shreeve, Ed.D.

*Teaching Clinical Methods to Sophomore Students*

Kenneth Walker, M.D., et al.

*Instructor-Patient Program at the University of Wisconsin*

Karen K. Anderson

*Non-Physicians as Instructors and Evaluators of Patient Assessment Skills*

Paula L. Stillman, M.D., et al.

*A Clinical Skills Instruction Program: The Acute Abdomen*

Robert M. Kretzschmar, M.D., et al.



*Checklist Evaluation of Physical Examination*  
Robert Petzel, M.D., et al.

*Talking with Patients: Teaching and Evaluating Interpersonal Skills*  
Marsha Grayson, et al.

*The Psychiatric Patient Evaluation Process*  
Robert E. Froelich, M.D., et al.

*"Human Caring Skills" Curriculum*  
Loretto Comstock

*Teaching Interpersonal Skills Development in a Medical Curriculum*  
Mary Edna Helfer

*A Physical Diagnosis Course Designed Through Evaluative Research*  
Thomas McGlynn, M.D., et al.

#### SMALL GROUP DISCUSSIONS

*Interdisciplinary Topic Inclusion in the Curriculum: Geriatrics*

Moderator: Peter E. Dans, M.D.

Panel: Ransom J. Arthur, M.D.  
L. Thompson Bowles, M.D.  
Carl Eisdorfer, M.D.  
Leonard A. Katz, M.D.  
Jack W. Lukemeyer, Ph.D.

*Continuing Education Network in the VA System: Regional Education Center Concept*

Moderator: David B. Walthall, M.D.

Panel: F. A. Zacharewicz, M.D.  
William F. Maloney, M.D.  
Mark W. Wolcott, M.D.  
Benjamin D. Wells, M.D.  
Makis J. Tsapogas, M.D.

*Health Services Planning: Implications of the Law for Medical Education Programs*

Moderator: James D. Bentley, Ph.D.

Panel: S. Philip Caper, M.D.  
Ray Cornbill  
Colin C. Rorrie, Jr., Ph.D.

*Alternate Healing Methods*

Moderator: Russell R. Moores, M.D.

Panel: Peter O. Ways, M.D.  
David Hufford, Ph.D.

*Curriculum Evaluation and the Curriculum Change Process*

Moderator: Robert L. Beran, Ph.D.

Panel: Robert L. Beran, Ph.D.  
Robert L. Tuttle, M.D.  
Sarah M. Dinham, Ph.D.

*Medical Ethics/Human Values*

Moderator: E. A. Vastyan

Panel: E. A. Vastyan  
Warren T. Reich, S.T.D.

*Criteria of Effective Performance by Students in Clinical Clerkships*

Moderator: Donald M. Hayes, M.D.

Panel: Xenia Tonesk, Ph.D.  
John C. Mueller, M.D.  
John E. Ott, M.D.  
Harold G. Levine  
Geoff Norman, Ph.D.

*Student Academic Support Programs*

Moderator: Miriam S. Willey, Ph.D.

Panel: Anna Epps, Ph.D.  
John G. Bruhn, Ph.D.

*Instructional Resource and Technology Units: Care and Nurture*

Moderator: Murray M. Kappelman, M.D.

Panel: Thomas Held, Ed.S.  
David Garloff, Ed.D.  
Dean Fenley, Ed.D.  
Carol Hampton

*Evaluating Faculty Effectiveness in Teaching*

Moderator: Winfield H. Scott, Ph.D.

Panel: Frank Schimpfhauser, Ph.D.  
W. Loren Williams, Jr., Ph.D.

#### GME/GSA JOINT PROGRAM

##### October 24

PROBLEMS IN STUDENT PROFESSIONAL DEVELOPMENT: WHO SHALL BE GRADUATED?

Moderator: Marilyn Heins, M.D.

Keynote: *Implications of the Horowitz Decision*  
Marvin E. Wright, L.L.D.  
Lee Langley, Ph.D., L.L.D.

*Assessing Student Performance: Non-Cognitive Criteria*

L. Thompson Bowles, M.D.

*Reconciling Evaluation and Advising*  
Robert I. Keimowitz, M.D.

*The Student/Consumer Viewpoint*  
Molly Osborne, Ph.D.

**GROUP ON PUBLIC RELATIONS**

**October 23**

Presiding: Kay Rodriguez

**ISSUES OF THE DAY**

Moderator: Vicki Saito

*The Bakke Decision*  
Donald Reidhaar  
Bart Waldman

*The Role of Public Relations in Hospital Cost Containment*

Moderator: Ruth Jacobwitz

Panel and Discussion

**October 24**

**THE PUBLIC AND HEALTH**

Moderator: Frank J. Weaver

*Public Attitudes Toward Health Care*  
George P. Van

*Patterns of Mass Media Utilization: How the Public Gets Health Information*  
Graham Ward

Moderator: Paul Van Nevel

*Pretesting Messages, Media and Strategies*  
William Novelli

Moderator: Joe Sigler

*Managing the Public Relations Function*  
William Mindak, Ph.D.

**October 25**

Nominee Presentations for Excellence In:

- Electronic Media
- Publications
- Special Projects
- Total Programming

Presiding: Bill Glance

Awards Luncheon

Presiding: Frank J. Weaver

Presentation of Awards  
John A. Gronvall, M.D.

Business Meeting  
Presiding: Frank J. Weaver

**GROUP ON STUDENT AFFAIRS**

**October 23**

Minority Affairs Section Regional Meetings

Minority Affairs Section Business Meeting

**October 24**

GSA Regional Breakfasts

GME/GSA Joint Program

PROBLEMS IN STUDENT PROFESSIONAL DEVELOPMENT: WHO SHALL BE GRADUATED?

**October 25**

GSA Regional Breakfasts

GSA Business Meeting

**PLANNING COORDINATORS' GROUP**

**October 22**

National Program

*The Coordination of Planning Functions in Contemporary Academic Health Institutions*

Speakers:

- Edmund Pellegrino, M.D.
- Charles C. Sprague, M.D.
- James A. Pittman, Jr., M.D.
- Arthur L. Gillis
- Michael T. Romano, Sr.
- George Stuehler, Ph.D.
- David R. Perry
- Thomas A. Rolinson
- Constantine Stefanu, Ph.D.

Business Meeting

Regional Meetings

**RESEARCH IN MEDICAL EDUCATION SEVENTEENTH ANNUAL CONFERENCE**

**October 25**

**POSTER SESSIONS**

*A Two-Phase Strategy for the Early Identification of Potential Academic Problems in Medical School*

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David S. Thomson, et al.

*Attitudes of Physicians in Four Different Specialty Areas Toward An Innovative Form of Continuing Medical Education*

Diane L. Essex, Ph.D., et al.

*Useful Statistical Procedures for Identifying Academically "At Risk" Medical Students*

David B. West, et al.

*How Medical Students Learn: A Case Study*

William H. Young, Ed.D., et al.

*Role of the Pathology Resource Center in Undergraduate Medical Education*

Joshua A. Fierer, M.D., et al.

*An Evaluation of Pediatric Clerkship Performance in a Multicomponent Evaluation System*

Robert G. Pierleoni, Ed.D., et al.

*Computer-Generated Problem Simulations as an Aid to the Development of Clinical Reasoning Skills—a Method for Training in Clinical Problem Solving*

John L. Gedye, M.D., et al.

#### PRESENTATION OF PAPERS

##### VALIDITY OF PMP'S

Moderator: Joseph S. Gonnella, M.D.

*Performance on PMP's and Performance in Clinical Practice: Are They Related?*

Gordon G. Page, Ed.D., et al.

*Computer-Based Problems as a Measure of the Problem-Solving Process—Some Concerns About Validity*

J. W. Feightner, M.D., et al.

*Construct Validity of Patient Management Problems: Emergency Versus Non-Emergency Contexts*

Michael B. Donnelly, et al.

*The Dimensionality of Linear Patient Management Problems*

Ernest N. Skakun

##### INSTRUCTIONAL AND FACULTY DEVELOPMENT

Moderator: Jon Wergin, Ph.D.

*Workshops: An Effective Format for Promoting Faculty Development in Family Medicine*

Carole J. Bland, Ph.D., et al.

*Medical Faculty Acceptance of Peer Reviewed and Recommended Audiovisual Programs*

Judith G. Calhoun, Ph.D.

*The Relationship Between Student and Faculty Instructional Preferences in Predicting Basic Science Course Performance*

Charles P. Friedman, Ph.D.

##### CONTINUING MEDICAL EDUCATION

Moderator: Phil R. Manning, M.D.

*Risk Factors of Heart Disease: A Survey of Texas Physicians and Implications for Continuing Education*

Lawrence Ullian, et al.

*Clinical Learning in Respiratory Disease: A Comparison of Computer-Assisted Instruction and Lecture Method*

Charles M. Plotz, M.D., et al.

*Improving Physician Performance by Continuing Medical Education*

O. E. Laxdal, M.D., et al.

*A Problem-Based, Self-Directed Educational Program in Neonatal Respiratory Disease for Community Hospital Personnel. I. Development*

H. S. Barrows, M.D., et al.

##### ASSESSMENT OF STUDENT SELECTION

Moderator: Paul R. Elliott, Ph.D.

*Assessment of Problem-Solving Skills as a Screen for Medical School Admissions*

John B. Molitor, Ph.D., et al.

*Cognitive and Personality Variables in the Prediction of Preclinical Performance*

Robert Roessler, M.D., et al.

*Monitoring the Process of Selection: The Identification of Successful Applicants by an Admissions Committee*

Louise Arnold, et al.

*Faculty Assessment of Medical School Admission Criteria*

Carl N. Edwards, et al.

##### INFLUENCES ON SPECIALTY CHOICE AND LOCATION

Moderator: Edwin B. Hutchins, Ph.D.

*The Cooperative Michigan Longitudinal Study of Medical Student Career Choice: Research Design and Preliminary Results*

J. Thomas Parmeter, Ph.D., et al.

*A Longitudinal Evaluation of Student Physician Experience in Primary Care and Its Effect on Residency Choice*

Marian Osterweis, Ph.D., et al.

*Factors Associated With Satisfaction in Rural Practice: The Medical School's Role*

Martin P. Kantrowitz, M.D., et al.

*Effects of Off-Site Experience on Medical Student Awareness and Interest in Rural Health Care Delivery*

Jane Elzey, et al.

HEALTH SERVICES AND EDUCATION

Moderator: Charles W. Dohner, Ph.D.

*An Ambulatory Care Information System For Evaluating Clinical Performance of Medicine Residents*

Roberta A. Monson, M.D., et al.

*The Validity of the Medical Record: A Comparison of Elicited and Recorded Clinical Data*

J. G. Wakefield, et al.

*The Cost of Student Instruction in the Practice Setting*

L. Gregory Pawlson, M.D., et al.

*Medical Student Instructional Costs in a Primary Care Clerkship*

L. Gregory Pawlson, M.D., et al.

PRESENTATION OF SYMPOSIA

IMPLICATIONS OF THE AAMC LONGITUDINAL STUDY FOR MEDICAL EDUCATION AND MEDICAL CARE DELIVERY

Chairman: James B. Erdmann, Ph.D.

Participants:

Xenia Tonesk, Ph.D.

Robert F. Jones

Discussants:

Lee Sechrest, Ph.D.

John S. Graettinger, M.D.

TEACHING THE INTERPERSONAL SKILLS OF MEDICAL INTERVIEWING

Organizer: J. Gregory Carroll, Ph.D.

Chairman: Edwin B. Hutchins, Ph.D.

Participants:

J. Gregory Carroll, Ph.D.

Judy Monroe

J. Dennis Hoban, Ed.D.

Mary Heider, Ph.D.

Joseph Stoner

John M. Schneider, Ph.D.

B. Kaye Boles, Ph.D.

Discussant: Joseph W. Hess, Jr., M.D.

STUDENT RATINGS OF INSTRUCTIONAL EFFECTIVENESS: IMPACT ON AND IMPLICATIONS FOR MEDICAL EDUCATION

Organizer: Marilyn A. Mendelson, Ph.D.

Chairman: Ronald Jordan, Ph.D.

Participants:

G. Robert Ross, Ph.D.

Carol J. Lancaster

Susan B. Bloodworth

Wayne K. Davis, Ph.D.

Stephen L. Manchester

Sara R. Frisch, Ph.D.

Josephine M. Cassie

Elizabeth Ritchie

George F. Collins

James H. Hardin, Ph.D.

Stephen D. Canaday, Ph.D.

Marilyn A. Mendelson, Ph.D.

ISSUES AND DIRECTIONS IN THE USE OF SMALL LEARNING GROUPS IN MEDICAL EDUCATION

Chairman: Evelyn B. McCarthy

Participants:

Joyce M. Jaffe, Ph.D.

Jay B. Forrest, Ph.D.

Parker A. Small, Jr., M.D.

SuiWah Chan, Ph.D.

Discussant: Dale Lefever, Ph.D.

ANALYSIS OF STRESS IN THE MEDICAL SCHOOL ENVIRONMENT: AN ALTERNATIVE APPROACH

Chairman: Jerry A. Royer, M.D.

Participants:

Jerry A. Royer, M.D.

Lois Huebner, Ph.D.

Donald L. Cordes, Ph.D.

James Moore

Louise Arnold, Ph.D.

Robert K. Marshall, Ph.D.

Carl N. Zimet, Ph.D.

Marc T. Edwards, M.D.

TOWARD A TESTABLE THEORY OF PHYSICIAN COMPETENCE: AN EXPERIMENTAL ANALYSIS OF A CRITERION-REFERENCED SPECIALTY CERTIFICATION TEST LIBRARY

Chairman: Jack L. Maatsch, Ph.D.

Participants:

Steven Downing  
Sarah Sprafka, Ph.D.  
Thomas Holmes, Ph.D.  
Jack Maatsch, Ph.D.

October 26

PRESENTATION OF PAPERS

MULTIPLE MEASURES OF STUDENT CLINICAL PERFORMANCE

Moderator: Robert M. Rippey, Ph.D.

*Relationships Between the Pre-Clinical and Clinical Years of Medical School: A Study of the Interrelatedness of Several Performance Measures*

Ralph A. Sirotkin, et al.

*Prediction of Graduate Clinical Performance Ratings From Multi-Component Medical School Examinations*

Rene L. Nerenberg, et al.

*A Study of the Predictive Validity of Patient Management Problems, Multiple Choice Tests and Rating Scales*

Michael B. Donnelly, et al.

*Six Years Experience With a Supervised Year of Training ("Fifth Pathway") For Americans Studying Medicine Abroad*

James E. Mulvihill, D.M.D., et al.

CLINICAL TEACHING

Moderator: Daniel S. Fleisher, M.D.

*Patient's Rights: An Approach to Informing and Instructing Teaching Patients Who Are To Be Evaluated by Sophomore Medical Students*

M. Albanese, et al.

*Pilot Experience of a Family Practice-Based Combined Clerkship*

L. Edmond Eary, M.D., et al.

*The Evaluation of On-Campus and Off-Campus Senior Electives*

M. A. Mendelson, Ph.D., et al.

*The Hospital Work of Family Physicians: A Comparison of Teaching Settings to Practice Settings*

Ronald C. Slabaugh, Ph.D.

INSTRUCTIONAL METHODS

Moderator: Sam Brown, Ed.D.

*Towards the Experimental Validation of Clinical Teaching Strategies*

Robert A. Petzel, et al.

*A Comparison of the Effects of Videotape Feedback, Instructor Feedback, and Checklist Feedback on Medical Student Performance of the Physical Examination*

William E. Shreeve, Ed.D., et al.

*An Effective Model for Teaching Sophomore Medical Students to Perform the Male Genital-Rectal Examination*

A. Behrens, et al.

*The Use of Peer Group Models in Breast, Pelvic and Rectal Examination Instruction as an Integral Part of Medical Gross Anatomy*

E. D. Prentice, Ph.D., et al.

EDUCATIONAL POTPOURRI

Moderator: Donald M. Gragg, M.D.

*A Method for Studying Medical Interviews: A New Taxonomy for Coding Verbal Interactions*

Samuel M. Putnam, et al.

*Identification of Physician Educational Influentials (EI's) in Small Community Hospitals*

Roland G. Hiss, M.D., et al.

*A Comparative Analysis of Residents' Goals for Training*

Evelyn R. Dienst, Ph.D., et al.

PATIENT VARIABLES IN QUALITY OF CARE

Moderator: John Corley, M.D.

*Teaching Strategies to Family Practice Residents to Improve Patient Adherence: Recent Advances in Social-Psychological Research*

Edward E. Bartlett

*Effects of Differences in Quality of Care on Patient Satisfaction and Other Variables: An Experimental Simulation*

John E. Ware, Jr., et al.

*Modifying House Staff Behavior: Physician Versus Patient Oriented Intervention*

P. Rudd, M.D., et al.

APPLICATION OF MODELS FOR CURRICULUM DEVELOPMENT AND EVALUATION

Moderator: Craig L. Gjerde, Ph.D.

*Strategy for Curriculum Planning*

Lawrence Tremonti, M.D., et al.

*An Empirical Comparison of Responsive and Preordinate Approaches to Program Evaluation*  
Gerry R. Schermerhorn, et al.

*Initial Evaluation of an Innovative Basic Sciences Program*  
V. Patel, et al.

*An Evaluation of an Undergraduate Oncology Curriculum by Time, Performance and Preference Dimensions from the Point of View of Function, Academic Discipline and Body Organ Systems*

Patricia M. Scalzi, et al.

#### PRESENTATION OF SYMPOSIA

LAW AND MEDICINE: APPROACHES TO UNDERGRADUATE MEDICAL SCHOOL CURRICULUM PROGRAMMING

Organizers:

Linda H. Coulter  
Theodore R. LeBlang

Chairman: Theodore R. LeBlang

Participants:

George J. Annas  
Barbara R. Grumet  
Angela R. Holder  
Theodore R. LeBlang

Discussant:

Salvatore Francis Fiscina, M.D.

ALTERNATIVE PROGRAMS IN MEDICAL EDUCATION: HOW WELL ARE THEY WORKING, AS MEASURED BY STUDENT PERFORMANCE?

Organizer: Louise Arnold, Ph.D.

Chairman: Ernest H. Blaustein, Ph.D.

Participants:

Melton E. Golmon, Ph.D.  
Harry W. Linde, Ph.D.  
T. Lee Willoughby  
Frederick W. Pairent, Ph.D.

Discussant: Stanley Olson, M.D.

TEACHING HEALTH CARE COST CONTAINMENT IN THE NATION'S MEDICAL SCHOOLS

Organizer: Mohan L. Garg, Sc.D.

Chairman: Joseph G. Giacalone

Participants:

Donald R. Korst, M.D.  
James E. Davis, M.D.  
Jack L. Mulligan, M.D.  
Carter Zeleznik, Ph.D.  
Joseph S. Gonnella, M.D.  
Mohan Garg, Sc.D.

Discussants:

Robert Stone, Ph.D.  
Michael J. Goran, M.D.  
Jane S. Mathews

THE RELATIONSHIP BETWEEN MORAL REASONING, TREATMENT OF THE CRITICALLY ILL, RESIDENT PERFORMANCE, AND ROLE CONCEPT

Chairman: T. Joseph Sheehan, Ph.D.

Participants:

Susan D. R. Husted  
Charles D. Cook, M.D.  
T. Joseph Sheehan, Ph.D.  
Daniel Candee, Ph.D.

Discussant: Bryce Templeton, M.D.

WHAT ARE THE NEW MEDICAL SCHOOLS DOING ABOUT CURRICULUM EVALUATION: AN INTERNATIONAL PERSPECTIVE

Chairman: Vic Neufeld, M.D.

Participants:

Christel Woodward, Ph.D.  
Cees van Boven, M.D.  
Rufus Clarke, M.D.  
Ascher Segall, M.D.

A NATIONAL STUDY OF PHYSICIAN PRACTICES IN TWENTY-FOUR SPECIALTIES: SELECTED FINDINGS

Organizer:

Stephen Abrahamson, Ph.D.

Chairman: John S. Lloyd, Ph.D.

Participants:

Roger A. Girard, Ph.D.  
Robert C. Mendenhall  
George P. DeFlorio  
Paul A. Repicky, Ph.D.

Discussants:

William D. Holden, M.D.  
C. H. William Ruhe, M.D.  
Alvin R. Tarlov, M.D.

# Minutes of AAMC Assembly Meeting

October 24, 1978

New Orleans Hilton Hotel, New Orleans, Louisiana

## Call to Order

Dr. Robert G. Petersdorf, AAMC chairman, called the meeting to order at 11:30 a.m.

## Quorum Call

The Chairman recognized the presence of a quorum.

## Consideration of Minutes

The minutes of the November 8, 1977, Assembly meeting were approved without change.

## Report of the Chairman

Dr. Petersdorf reported that the Association and its constituents had been involved in a number of court cases during the past year, most notably the *Bakke* case in which the AAMC had filed an *amicus curiae* brief and acted as a supplier of data and coordinator of information for the university, the federal government and other amici. The Association had also filed an *amicus* brief in *Kountz v. the State University of New York*, a case that challenged the authority of an institution to regulate the practice income of the physician members of its full-time faculty. Although the Association played no direct role in the case of *Horowitz v. the Regents of the University of Missouri*, information on the court's decision reaffirming the university's role in regulating academic standards and promotions was distributed by the Association to constituents. In *Chrysler v. Brown* the Association acted in its *amicus* to alert the court to the adverse impact on the rights of academic scientists that would result from a decision that the government can release information exempt from the Freedom of Information Act. Recent Executive Council ac-

tion had authorized the filing of *amicus curiae* briefs in two additional cases. In *Cannon v. the University of Chicago* the issue pertained to whether Title IX of the Education Amendments of 1972 prohibiting discrimination on the basis of sex conferred a private right of action or whether a disappointed applicant must first comply with the administrative remedies in the statute. *Shapp v. Sloan* involved whether a state legislature can reappropriate federal funds for educational institutions or whether the Board of Regents retains autonomy for the governance of the academic institution. Dr. Petersdorf also reported on the work of a number of task forces and committees of the Association, including the Task Force on Student Financing and the Task Force on Minority Student Opportunities in Medicine, the final reports of which were adopted by the Executive Council. The Executive Council also adopted reports from Ad Hoc Committees on Biomedical and Behavioral Research and Training and Section 227 of the Medicare Law. The activities of the two ongoing Task Forces on Support of Medical Education and Graduate Medical Education were also discussed.

The Association had been involved in efforts undertaken by the Department of Health, Education and Welfare, and particularly the National Institutes of Health, to develop an HEW plan to support health research, and the Association had also begun to review medical faculty involvement in research regulated by the Food and Drug Administration.

The Association's activities with respect to Section 227 regulations were detailed and Dr. Petersdorf reported that Secretary Califano had announced that the implementation of the regulations would be delayed and that the Asso-

ciation would continue to discuss its concerns with HEW staff.

Finally, Dr. Petersdorf reported that Congress had adjourned without acting on H.R. 2222, a bill to treat house staff as employees for the purposes of the National Labor Relations Act. He reported that this legislation would undoubtedly be introduced in the next Congress.

### **Report of the President**

Dr. John Cooper reported that the Association had completed its activities funded under a major Bureau of Health Manpower contract, and had successfully initiated a number of new projects including a joint venture with the Veterans Administration to develop criteria and standards for evaluating continuing medical education programs, a Health Care Financing Administration project to develop a primer on teaching cost containment and quality assurance to medical students, and an expansion of the AAMC Simulated Minority Admissions Exercises program.

Dr. Cooper had served as chairman of the Coordinating Council on Medical Education since last March. The major effort of the Association had been to strengthen the Liaison Committee on Graduate Medical Education by supporting the establishment of an independent staff and by reaffirming the LCGME's authority as the accrediting agency for graduate medical education programs.

The number of medical school applicants for fall 1978 had declined by 9.1 percent over those applying in the previous year, although when the number of available freshman places was at an all-time high. The Association planned to study the drop in applicants and the impact the overall decline had on the number of women and minority students. Health manpower issues continued to play a major role at the Association during 1978, as manifested in discussions by the Association's task forces, the adoption of an interim position paper by the Executive Council on specialty distribution, and in continued negotiations with Congressional and agency personnel preparing for new health manpower legislation in the next Congress. Dr. Cooper also discussed Congressional changes occurring because of Congressman Rogers' retirement and the assumption of the Judiciary

Committee chairmanship by Senator Edward Kennedy. Dr. Cooper said that many health bills would be debated in the new Congress including cost containment, drug regulation and reform, health planning amendments, Medicare and Medicaid fraud and abuse legislation, and the Clinical Laboratories Improvement Act. Congress had taken final action on the appropriations bill setting a level for medical school capitation payments at about \$1,325 per student, a slight decrease over the level of the previous year.

Also, Dr. Cooper stated that in recent conversations with Dr. James Crutcher, the new chief medical director of the Veterans Administration, he had received assurances that proposed cutbacks in the VA residency training programs had been restored. Dr. Crutcher had promised to continue to work closely with the AAMC to maintain a good relationship between his agency and the medical schools.

### **Report of the Council of Deans**

Dr. Julius Krevans reported that the Council of Deans had been actively involved in reviewing Association policies during the past year and had no new business to present to the Assembly.

### **Report of the Council of Academic Societies**

Dr. Robert Berne reported that the Council of Academic Societies had elected six new members. He also reported that the Council had spent much of its time formulating the policy statement on Biomedical Research and Behavioral Research Training that the Executive Council had endorsed. Further efforts were underway to work with the Department of Health, Education, and Welfare to develop that agency's research policy. During the course of the year the CAS had met with Dr. Carl Douglas of the NIH Division of Research grants to discuss the peer review system and with Dr. Richard Crout of the Food and Drug Administration to discuss the effect of FDA regulation on research conducted by medical school faculty.

The CAS would sponsor a Public Affairs Workshop during the latter part of the annual meeting and would hold an interim meeting in the spring.



### Report of the Council of Teaching Hospitals

Mr. David Everhart reported that the COTH had begun sponsorship of a spring meeting to increase opportunities for its members to become involved in the formulation of Association positions. Two important issues considered by COTH during the year were cost containment and the concept of multi-hospital systems.

### Report of the Secretary-Treasurer

Mr. Everhart reviewed the published treasurer's report and reminded the Assembly of the Executive Council's goal of reserving the equivalent of one year's operating funds, and further reported that at the conclusion of the last fiscal year the reserves were equal to 82 percent of that goal. Mr. Everhart also paid special tribute to J. Trevor Thomas, director of business affairs, for his oversight of the financial affairs of the Association.

*ACTION: On motion, seconded, and carried, the Assembly accepted the report of the Secretary-Treasurer*

### Report of the Organization of Student Representatives

Mr. Paul Scoles reported that major OSR activities involved finding ways of making more information on graduate medical education programs available to students and reviewing options in financing medical education.

### Election of New Members

*ACTION: On separate motions, seconded, and carried, the Assembly by unanimous ballot elected the following-institutions and individuals to the indicated classes of membership.*

*Provisional Institutional:* Marshall University School of Medicine; Catholic University of Puerto Rico School of Medicine; School of Medicine at Morehouse College; and East Tennessee State University College of Medicine.

*Academic Society:* American Society of Hematology; American Society of Pharmacology and Experimental Therapeutics; Association of Academic Departments of Otolaryngology; Association for the Behavioral Sciences and Medical Education; Society for Neuroscience; and Thoracic Surgery Program Directors.

*Teaching Hospital:* Baroness-Erlanger-T.C Thompson Childrens Hospitals, Chattanooga, Tennessee; Charles F. Kettering Memorial Hospital, Kettering, Ohio; Children's Hospital Medical Center, Cincinnati, Ohio; Good Samaritan Hospital and Health Center, Dayton, Ohio; Jerry

L. Pettis Memorial Veterans Hospital, Loma Linda, California, Sinai Hospital of Detroit, Detroit, Michigan; and University of Massachusetts Hospital, Worcester, Massachusetts

*Corresponding.* Mercy Hospital, Urbana, Illinois; North Chicago Veterans Administration Hospital, North Chicago, Illinois, Orthopaedic Hospital, Los Angeles, California; Southwestern Michigan Area Health Education Center, Kalamazoo, Michigan, Veterans Administration Hospital, Fayetteville, North Carolina.

*Individual:* (List attached to archive minutes.)

*Distinguished Service.* Leonard W. Cronkhte, Jr., M.D.

*Emeritus:* Donald G. Anderson, M.D., T Stewart Hamilton, M.D., John S Hirschboeck, M.D.; Russell A. Nelson, M D , and Edward C Rosenow, Jr., M.D

### Report of the Finance Committee

Mr. Charles Womer stated that the Finance Committee report had been presented to the Council of Deans and to the Council of Teaching Hospitals at their spring meetings and to the Administrative Boards of all three Councils and endorsed by each group. The Finance Committee had recommended that although the Association was in good financial health, an increase in the dues structure beginning in fiscal year 1980 be made to assure that the Association was able to meet the challenges that lie ahead. The recommended changes include an inflator imposed on dues and service fees that would be subject to waiver or decrease by action of the Executive Council.

*ACTION: On motion, seconded, and carried, the Assembly approved the report of the Finance Committee recommending a raise in institutional and organizational dues. (Copy of report attached to archive minutes.)*

### Eligibility for Continuing COTH Membership

Mr. Everhart explained that there were two categories of COTH membership: Teaching Hospital membership and Corresponding membership. Both membership categories required the applicant institution to have a documented affiliation agreement with a medical school accredited by the LCME, and a letter recommending membership from the dean of the affiliated medical school. Teaching Hospital membership was limited to not-for-profit and publicly owned hospitals that sponsor or significantly participate in at least four approved active residency programs, at least two

of which are in the areas of internal medicine, surgery, obstetrics-gynecology, family medicine, or psychiatry. A staff study of COTH members revealed that 24 COTH members lacked the required signed affiliation agreement, six COTH members sponsored or participated in three or fewer residency programs, and three members had fewer than two residencies in the required specialties. The Executive Council recommended the following revisions in COTH membership requirements:

1. That hospitals belonging to COTH prior to July 1, 1978, without a signed affiliation agreement be retained as members provided they continue to maintain the required number of residencies
2. That Teaching Hospital members that either do not sponsor or participate in four approved residency programs or do not have two programs within the required basic six residencies be reclassified as Corresponding Members effective July 1, 1979.
3. That the NIH Clinical Center be retained as a full Teaching Hospital member recognizing its specialty care nature.

*ACTION: On motion, seconded, and carried, the Assembly approved the recommendations of the Executive Council with respect to continuing COTH membership in the AAMC*

### Statement on Withholding of Medical Care By Physicians

Dr. Clayton Rich reported that the statement on withholding of medical care by physicians had been adopted by the Executive Council in response to Association concern about physicians withholding services to make social or economic points. He further explained that the statement did not proscribe withholding of services, but emphasized the seriousness of the ethical issues that must be considered in such a decision.

*ACTION: On motion, seconded, and carried, the Assembly adopted the following statement on withholding of medical care by physicians:*

Fundamental ethical tenets of the medical professions mandate that physicians provide care for the sick and neither abandon or exploit their patients. These ethical tenets apply to physicians whether they are acting individually or in concert as members of groups or associations.

An important ethical issue, one not ordinarily present in the traditional relationship between an individual physician and his patients, emerges when physicians act together to restrict or withhold medical services. An individual physician

need not accept as his patient every person who seeks medical attention because, in most situations, alternative sources of care are available. However, the option of alternative care may be foreclosed when physicians act together to limit or withhold medical care. It is clear that physicians acting in concert have an ethical responsibility to all of those in the general public who could be patients of individual physicians had a group decision denying them some form of medical care not been made. When such a decision is implemented by all available physicians, these physicians abandon members of the public seeking medical care. Therefore, physicians who act in concert to restrict or withhold medical care contravene some of the profession's primary ethical precepts.

(Physicians are, of course, justified in refusing to perform procedures or acts designed to further inherently corrupt or evil purposes. Indeed there is an ethical mandate that they do so, but such acts are not properly defined as medical care.)

In the recent past groups of physicians have acted to restrict or withhold medical care in order to call attention to social issues, such as the need to improve the quality of care afforded one segment of the public. An analysis of the ethical considerations raised by this practice begins with the recognition that physicians are members of the public with special knowledge and experience which provide a unique perspective on the conditions of medical practice, the relations between the profession and the public and the major social issues involving health and welfare. Physicians acting individually or together have a special social responsibility to provide advice and leadership in such matters. However, in advancing positions about social issues, physicians act as specially informed citizens, not from their unique and primary positions as healers. Any attempt to justify on ethical grounds the decision to restrict medical care in order to advance an assumed social good confounds the specific role of physicians in society as providers of healing services, with a more general role shared with all other citizens. These considerations make it doubtful that a justification reasonably can be advanced. To the extent that an element of self-interest motivates a decision to limit or withhold professional services, ethical justification of that stance is even more suspect.

Because the ethics and public duty of the profession restrain physicians from acting in concert to withhold services, they should avoid this powerful method of advancing their interests. It is a responsibility of society to forego exploitation of this ethical standard by providing a fair process for resolving valid economic and organizational issues which influence the welfare of the profession and the quality of medical care.

The Association of American Medical Colleges reaffirms its support of fair processes for resolving concerns of medical professionals and

opposes the withholding of medical care by groups of physicians as a means of resolving such issues.

### **Report of the Task Force On Support of Medical Education**

Dr. Stuart Bondurant reported on the activities of the Task Force on Support of Medical Education. In its draft report the Task Force recommended that:

1. Broadbased support, equal to one-third of the average national cost of medical education (as determined by established methodologies), be an integral part of health manpower renewal legislation.

2. Programs of federal assistance to medical schools be implemented primarily through incentives rather than through detailed specifications of institutional operations, have continuity of purpose, respect the health and integrity of the responsible institution, and permit institutional diversity within the framework of national objectives

3. Direct federal institutional support to medical schools continue to be the primary vehicle of federal assistance.

4. Institutional support grants coupled with appropriate conditions for participation be requested.

5. There be no expansion of medical school enrollments for three to five years while information is gathered to support a reasoned decision on whether a change in physician production would serve the national interest.

6. Special projects be continued, but not as the preferred or primary mechanism for the support of medical education.

7. Most current special projects such as AHEC be continued and new programs in education in the principles of cost containment and a special assistance program for schools with significant minority enrollments be implemented.

8. The recommendations of the AAMC Task Force on Student Financing be supported.

9. Careful assessment of the status of medical education facilities be undertaken and that the medical educational facilities program be revitalized.

Copies of the complete draft report were made available to Assembly members who were invited to submit comments to the Task Force.

### **Report from the Task Force On Graduate Medical Education**

Dr. Jack Myers, chairman of the Task Force on Graduate Medical Education, reported that the task force hoped to present its final report

to the 1979 Assembly. The task force had divided into five working groups on Transition from Undergraduate to Graduate Medical Education, Quality, Accreditation, Specialty Distribution, and Financing. The task force had worked closely with the Graduate Medical Education National Advisory Committee, and other groups that were also studying various aspects of graduate medical education.

### **AAMC Working Paper on Specialty Distribution**

Dr. Petersdorf reported that the Executive Council had adopted an interim working paper on specialty distribution for use in discussions with persons working on new health manpower legislation. The working paper recommended a goal of 50 percent of U.S. medical graduates entering careers in primary care; that the number of first year residency positions filled in surgical and other nonprimary care specialties remain at the 1977-78 level; that the number of entering positions for subspecialty training in internal medicine and pediatrics be decreased by one-third, with half of the remaining positions in programs emphasizing careers in research and academic clinical practice; that the organizations, institutions and program directors responsible for graduate medical education adopt these principles in the public interest and work for their implementation; and that the Liaison Committee on Graduate Medical Education establish a registry of subspecialty programs and develop an accreditation mechanism to assure the quality of subspecialty training programs. The issues addressed in the Working Paper would be dealt with in more detail in the final report of the Task Force on Graduate Medical Education.

Comments from the floor indicated the hope that the final report would recommend continued support for family practice training programs, and that the final report of the Task Force on Graduate Medical Education would be submitted to the membership for detailed discussion before its adoption.

### **Final Report of the Task Force On Minority Student Opportunities in Medicine**

Dr. Paul Elliott, chairman of the Task Force on Minority Student Opportunities in Medi-

cine, reported that the task force had completed its work and its final report had been adopted at the September Executive Council meeting. The principal goals of the report were:

1. Increase the pool of qualified racial minority applicants to levels equivalent to their proportion in the U.S. population with progress toward that goal reviewed on a biennial basis.

2. Enlarge the number of qualified racial minority students admitted to medical schools through continued improvement of the selection process

3. Emphasize the importance of financial assistance for racial minority group students pursuing careers in medicine

4. Strengthen programs which support the normal progress and successful graduation of racial minority students enrolled in our medical schools.

5. Increase the representation of racial minority persons among basic science and clinical faculties

6. Encourage the establishment of faculty development programs aimed at fostering an understanding of the history and culture of racial minority groups and at improving the quality of medical school instruction.

7. Insure that graduate medical education needs and opportunities for racial minority student are met.

#### **Report of the Resolutions Committee**

There were no resolutions presented to the Resolutions Committee for timely consideration and referral to the Assembly.

#### **Resolution on Research Opportunities For Undergraduate Medical Students**

Mr. Paul Scoles offered the following resolution from the Organization of Student Representatives:

Whereas, firsthand research experience contributes greatly to the development of scientific thought processes which are of value in all areas of medicine and continuing education;

Whereas, medical undergraduates have the opportunity to devote smaller blocks of time to research endeavors than is required for post-graduate research commitments,

Whereas, many medical students have been unaware of the opportunities or have been unable to fully utilize such opportunities because of problems with scheduling, funding, and so forth;

Be it therefore resolved that the COD, OSR, and CAS form a joint committee to investigate possibilities for improving and encouraging research opportunities, basic as well as clinical, for medical students with an interest towards funding, scheduling, and student research presentations.

*ACTION: On motion, seconded, and carried unanimously, the Assembly approved the resolution proposed by Mr. Scoles and the Organization of Student Representatives*

#### **Report of the Nominating Committee**

Dr. Jack Eckstein, Chairman of the AAMC Nominating Committee, presented the report of the Nominating Committee. The Committee is charged by the Bylaws with reporting to the Assembly one nominee for each officer and member of the Executive Council to be elected. The following slate of nominees was presented: Chairman-Elect: Charles B. Womer; Executive Council, COD representatives: Clayton Rich, M.D., William H. Luginbuhl, M.D., John E. Chapman, M.D.; Executive Council, CAS representative: Carmine D. Clemente, Ph.D.; Executive Council, COTH representatives: John W. Colloton, Stuart J. Marylander.

*ACTION: On motion, seconded, and carried, the Assembly approved the report of the Nominating Committee and elected the individuals listed above to the offices indicated.*

#### **Installation of Chairman**

Dr. Petersdorf presented the gavel to Dr. John A. Gronvall, the new AAMC chairman. Dr. Gronvall expressed the appreciation of the Association for Dr. Petersdorf's leadership.

#### **Adjournment**

The Assembly was adjourned at 1:05 p.m.

# Annual Report

## Message from the President

*John A. D. Cooper, M.D.*

Each year the activities of the Association and its constituents become more inextricably related to federal and state governments. In the past this cooperative relationship has benefited both parties; for example in the creative partnership forged to advance biomedical research or in the responsiveness of medical schools to past federal concerns about the adequacy of physician manpower production. Recently, however, the delicate balance necessary to maintain a productive relationship has begun to fail. The threat to our institutions of medical education—and to society—should this balance be destroyed has led to extensive review within the Association as to how such a partnership can be continued with mutual benefit. It is critically important that the diversity and independence of the academic medical centers be preserved even as we recognize the expectation of society that these institutions will provide needed services to the nation. The educational mission of medical schools has been assailed by federal efforts to direct the admissions process. Although the most notorious occasion was the “USFMS provision” of recent manpower legislation, federal regulations on nondiscrimination against the handicapped offer the threat of further governmental interference in an area long held to be within the institutional autonomy of a university. Despite the spectre of increasing government involvement in academic decisions, the Association was heartened this year by two Supreme Court decisions affirming the independence of schools in traditionally academic areas. In *Board of Curators of the University of Missouri v. Horowitz* the Court reiterated its faith in the ability of academic institutions to evaluate the performance of their students fairly and impartially. The celebrated case of *Regents of the University of California v. Allan Bakke* reaffirmed the right

of schools to use a variety of selection factors including race to achieve a goal of diversity in the student body.

Government concern about specialty and geographic distribution of physicians has been manifested in efforts to hold medical schools accountable for the individual career choice decisions of their graduates. Efforts to enforce a national standard on all schools would threaten the diversity of medical education and ignore the advantages of a pluralistic approach to physician education.

The patient care activities of academic medical centers and their teaching hospitals are more thoroughly regulated than ever before, and it frequently seems that the complexities inherent in a patient care setting with corollary missions of research and teaching are inadequately considered in the promulgation of regulations. Concern about rising health care costs has made cost containment a national priority, but the regulatory approach to teaching institutions/tertiary care centers has been inconsistent and paradoxical. In some instances teaching hospitals have been singled out for special restrictions; in others, there has been a failure to acknowledge the special role of the teaching institution. Similarly, local and state health services planning efforts frequently ignore the unique position and contributions of teaching institutions.

Biomedical research in this country has long been a model of productive participation by the private academic and scientific community in meeting goals articulated by the public sector. The peer review system at the National Institutes of Health has particularly succeeded in coupling input from the private sector with the allocation of federal funds. The keystone in this arrangement has been the implicit ac-

knowledge that the impartial assessment of research proposals by prominent scientists results in funding those research efforts most likely to contribute to improving health through increasing biomedical knowledge. Several trends in recent years now jeopardize this very effective system. There has been an increasing tendency on the part of the government to favor centralized direction of biomedical research at the expense of traditional investigator-initiated research. Further, despite the growth in the country's research enterprise and a substantial increase in research applications to NIH, support and staff for the peer review system have remained virtually unchanged. The net result has been a severe erosion of the capability for effective and timely scientific review. A final threat to the biomedical research effort has been the periodic attempt by the government to inject public participation into the decision-making processes for research. While the Association strongly supports public accountability in all aspects of the activities of its constituents, too often the increase in public participation is at the expense of the scientists most knowledgeable about the policy in question.

Inevitably it is a perceived lack of concern by the private sector that invites regulation by

the government. The responsibility of our medical schools when accepting public funds cannot be limited to an audit statement that funds were properly expended; responsibility also encompasses the need to work with the government to identify ways to achieve public goals. Failure to respond in a cooperative manner will result in increased government impositions and regulation, making it more difficult for medical schools to make their unique contributions to the improvement of the quality of life. The Association believes that progress in seeking solutions to our health problems can best be achieved when schools retain the flexibility to be innovative; a pluralistic approach to problem-solving offers better opportunity for success. We are strongly committed to a policy using incentives rather than regulation to implement public goals, to maintaining creative diversity among medical schools, and to increasing medical school sensitivity and responsiveness to public needs. Anne Somers has stated, "Of all the communications gaps in our complex pluralistic society, none is greater than that between academic medicine and the general public." The Association rededicates itself to improving communications between our constituents and the public and its representatives.

**Executive Council, 1977-78**

Robert G. Petersdorf, chairman  
John A. Gronvall, chairman-elect  
John A. D. Cooper, president

**Council Representatives:**

COUNCIL OF ACADEMIC SOCIETIES

Robert M. Berne  
A. Jay Bollet  
Daniel X. Freedman  
Thomas K. Oliver, Jr.

DISTINGUISHED SERVICE MEMBER

Robert J. Glaser

COUNCIL OF DEANS

Steven C. Beering  
Stuart Bondurant

Christopher C. Fordham, III  
Neal L. Gault, Jr.  
Richard Janeway  
Julius R. Krevans  
William H. Luginbuhl  
Clayton Rich  
Robert L. Van Citters

COUNCIL OF TEACHING HOSPITALS

John W. Colloton  
David L. Everhart  
Robert M. Heyssel  
David D. Thompson

ORGANIZATION OF STUDENT REPRESENTATIVES

Paul Scoles  
Peter Shields

**Administrative Boards of the Councils, 1977-78**

COUNCIL OF ACADEMIC SOCIETIES

Robert M. Berne, chairman  
Thomas K. Oliver, Jr., chairman-elect  
F. Marian Bishop  
A. Jay Bollet  
David M. Brown  
Carmine D. Clemente  
G.W.N. Eggers, Jr.  
Daniel X. Freedman  
James B. Preston  
Samuel O. Thier  
Frank C. Wilson, Jr.  
Frank E. Young

COUNCIL OF DEANS

Julius R. Krevans, chairman  
Christopher C. Fordham, III, chairman-elect  
Steven C. Beering  
Stuart Bondurant  
John E. Chapman  
Neal L. Gault, Jr.  
Richard Janeway  
William H. Luginbuhl  
Clayton Rich  
Robert L. Van Citters

COUNCIL OF TEACHING HOSPITALS

David L. Everhart, chairman  
Robert M. Heyssel, chairman-elect  
John W. Colloton  
Jerome R. Dolezal  
James M. Ensign  
Lawrence A. Hill  
Stuart Marylander  
Stanley R. Nelson  
Mitchell T. Rabkin  
Malcom Randall  
John Reinertsen  
Elliott C. Roberts  
David D. Thompson  
Robert E. Toomey

ORGANIZATION OF STUDENT REPRESENTATIVES

Paul Scoles, chairperson  
Peter Shields, chairperson-elect  
Fred Emmel  
Clayton Griffin  
Cheryl Gutmann  
Michael Mahl  
James Maxwell  
Dan Miller  
Molly Osborne  
Thomas Rado  
Dennis Schultz

# The Councils

## Executive Council

At its four meetings the Executive Council discussed and acted on many issues affecting medical schools and teaching hospitals and their faculty and students. Policy questions came to the attention of the Executive Council from member institutions or through one of the constituent Councils. Policy matters considered by the Executive Council were first referred to the constituent Councils for discussion and recommendation before final action.

The December retreat for the Association's elected officers and executive staff allowed participants to review the Association's relationship with other organizations concerned with medical education, particularly the Coordinating Council on Medical Education, the Liaison Committee on Medical Education, the Liaison Committee on Graduate Medical Education, and the Liaison Committee on Continuing Medical Education. Participants also focused attention on areas in which new federal legislation was expected, such as biomedical research policy and the national health planning program. The role of the Association in developing statements on ethical issues of concern to its constituency received considerable discussion, and recognition of the Association's responsibilities in this area led during the year to Executive Council consideration of a statement on financial considerations for admission to medical school, involvement of medical school faculty with foreign medical schools, privately sponsored research in academic settings, and withholding of services by physicians. As a result of Retreat discussions, the AAMC staff explored activities to assist medical schools and teaching hospitals to increase their role in educating the public about awareness of health risks and the practice of better health standards. Another Retreat discussion item receiving further attention at Executive Council meetings concerned ways of improving communications among the Association's officers, staff, and constituents.

The Association's participation in the Coordinating Council on Medical Education was

actively reviewed throughout the year. Particular attention was paid to CCME reports on the future staffing of CCME, policy planning for physician distribution, women in medicine, and residency positions for foreign medical graduates. The Executive Council strongly supported the establishment of an independent staff for the Liaison Committee on Graduate Medical Education, and reaffirmed the LCGME's authority as the accrediting agency for graduate medical education programs. The Executive Committee also urged the CCME to develop a long-range financing plan for the Liaison Committee on Continuing Medical Education.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of specially constituted committees and task forces. Two major AAMC task forces completed their work and presented final reports to the Council. The Task Force on Minority Student Opportunities in Medicine, chaired by Dr. Paul Elliott, finished a comprehensive review of the problems faced by medical schools in seeking to increase the enrollment of minority students and the problems encountered by minority applicants seeking medical education. The Executive Council endorsed recommendations to increase the pool of qualified racial minority applicants to a level equivalent to their population proportion, to emphasize the importance of financial assistance for minority students, to improve the selection process, to strengthen programs to retain minority students in medical schools, to increase minority representation on medical school faculty, to foster faculty understanding of minority students, and to ensure that the graduate medical education needs of minorities are met.

Dr. Bernard Nelson, Chairman of the Task Force on Student Financing, presented a final report which analyzed the shortcomings of existing student financial aid programs and offered recommendations for improving such programs.

The Executive Council also adopted a position paper on Biomedical and Behavioral Re-



search Policy prepared by a committee under the leadership of Dr. Robert Berne.

The work of two other major AAMC task forces continued.

The Task Force on the Support of Medical Education, under Dr. Stuart Bondurant's chairmanship, held three meetings during the past year and conducted a large portion of its business through working groups on the relationship of the university to the federal government and the rationale for continuing federal support, the character and need for financial support of medical education institutions, number and distribution of physicians, the role of medical schools in cost containment, and special initiatives.

The Task Force converged on a series of preliminary recommendations for submission to the Executive Council. However, in view of the unstable and unpredictable political situation facing the health industry in the wake of Congressman Paul Rogers' announced retirement from the House of Representatives, the Task Force decided that its first set of recommendations should be of a general and not a specific nature, and included the following:

1. Institutional support on the part of the Federal Government should be continued and should approximate one-third of the national aggregate medical education bill.
2. In recognition of the fact that a basic entitlement grant, though justified, was unrealistic, the Association should set forth standards for appropriate *quid pro quos* which would reflect both propriety in academic/government relationships as well as sound public policy objectives.
3. Enrollment increases over the next three to five years would be unwise.
4. The acceptance of the report of AAMC Task Force on Student Financing on income contingent loan programs.

Dr. Jack D. Myers, chairman of the Task Force on Graduate Medical Education, designated five working groups to focus on concerns of major import to this study. A Working Group on the Transition Between Undergraduate and Graduate Medical Education, chaired by Dr. Kay Clawson, studied the problems at the interface between these phases in the education and training of physicians. The group recommended that steps be taken to improve

the amount and quality of information available about graduate programs; that the application cycle be modified to increase the time available for decision-making; that letters of evaluation and transcripts not be supplied by deans and faculty until the fall of a student's final year; that interview schedules by graduate programs be sufficiently flexible to accommodate students' needs at the least expense; and that only two types of first graduate year programs be offered—categorical and mixed. The Working Group on Quality led by Dr. Samuel B. Guze considered institutional responsibility to assure the quality of their graduate programs. The group is also studying how program directors and faculty can improve the quality of their educational programs and their evaluation of residents' performance. A Working Group on Accreditation under the chairmanship of Dr. Gordon W. Douglas began deliberations in the fall. Other working groups on specialty distribution and financing graduate medical education will report to the Task Force. The W. K. Kellogg Foundation, the Education Foundation of America, and the Henry J. Kaiser Family Foundation have supported the work of the Task Force.

In response to Department of Health, Education and Welfare regulations on the admission of handicapped persons to education programs, the Executive Council established a Special Advisory Panel on Technical Standards for Medical School Admission. The Panel met with a representative of HEW's Office of Civil Rights to discuss the impact of the regulations on medical schools. Primary concerns of the Panel are maintenance of the M.D. degree as a broad, undifferentiated degree, and protection of the integrity of the admissions process.

A key Supreme Court decision in the case of *Regents of the University of California v. Allan Bakke* approved the use of race as one factor in the selection of students. Although the use of specific quotas based on race is not permissible, the Court's decision does support affirmative action programs. In an *amicus curiae* brief the Association had urged that the constitutionality of special minority admissions programs in medical schools be upheld. *Chrysler v. Brown* provided an opportunity for the Association to file an *amicus* brief supporting the use of Exemption 4 of the Freedom of Information Act

to maintain the confidentiality of the NIH peer review process and protect the proprietary rights of NIH applicant scientists.

The Executive Council this year responded to a series of questions posed by Rep. Paul Rogers, chairman of the Subcommittee on Health and Environment of the House Committee on Interstate and Foreign Commerce, concerning the conduct in public or publicly-funded schools or research centers, of directed research funded by profit-making enterprises with economic interests in the research outcome. A position paper on the responsibilities of institutions and individuals engaged in industry-sponsored research and consultation was prepared as a discussion document for use by constituent medical schools. The working paper was also used to initiate a dialogue on this subject with university presidents since the problems transcended the medical school and affected other departments within the university as well.

Periodic allegations of improprieties in the admission process of some medical schools prompted the Executive Council to reaffirm its long-standing policy that admission of students to medical schools should be based on their individual merits and the probability that they will fulfill goals established by the institution; no actual or perceived relationship between admission and financial contributions should exist.

A number of students who aspired to be physicians but who were not admitted to a U.S. medical school entered medical training in newly developing off-shore medical schools. Information received by the Association indicated that many of these schools were of substandard quality, and some were soliciting U.S. faculty members to serve as visiting professors. U.S. teaching hospitals were also asked to provide clinical clerkships for students. The Executive Council urged faculty and hospitals considering such arrangements to exercise due caution and to become familiar with the quality of the educational experience offered at the foreign institution before lending their names, services, or facilities.

Information provided to the Council of Deans and the Council of Academic Societies on the peer review system at the National Institutes of Health caused grave concern

within the Executive Council. A significant increase in capacity of the nation's biomedical research enterprise and an enormous increase in NIH research grant applications, when coupled with decreases in study section staff and administrative rulings increasing access to application review files, have jeopardized the integrity of the peer review process. At the direction of the Executive Council, staff developed a working paper that was distributed to all members of the Assembly.

After considering the desirability of acting on new health manpower legislation, Congress decided not to amend existing statutes. However, intensive activity in both the public and private sector on issues relating to physician manpower continued. The Executive Council reviewed major reports issued by the CCME, the General Accounting Office, and the Institute of Medicine, and the Executive Committee has been designated as a special subcommittee to review manpower issues.

Cost containment initiatives were also the subject of considerable discussion at Executive Council meetings. Although the Council supported the recommendations of the National Steering Committee on Voluntary Cost Containment, it made four recommendations to the Committee: that allowances be made for changing hospital expenditures resulting from increasing ambulatory care services; that guidelines and procedures not discriminate against hospital-based physicians and capital expenditures; that allowances be made for increased costs resulting from new accredited manpower training programs; and that scope of services and patient mix be considered in cost containment programs.

During the year the Executive Council continued to oversee the activities of the Group on Student Affairs, the Group on Medical Education, the Group on Business Affairs, the Group on Public Relations, and the Planning Coordinators' Group. Groups submit progress reports twice a year.

Prior to each Executive Council meeting the Executive Committee met and business was conducted by conference calls as necessary.

The Executive Council, along with the AAMC secretary-treasurer, Executive Committee, and Audit Committee, exercised careful scrutiny over the Association's fiscal affairs,

and approved an expanded general funds budget for fiscal year 1979. The revision of the dues structure and provisions for inflation-related increases, as recommended by the Finance Committee, were approved.

## Council of Deans

The Council of Deans sponsored two programs at the 1977 annual meeting in Washington, D.C. The first, *Analyzing the Veterans Administration/Medical School Relationship*, held in conjunction with the Council of Teaching Hospitals and the Veterans Administration, featured representatives from the General Accounting Office, the VA, and medical schools. The second program was jointly sponsored with the Council of Academic Societies and the Council of Teaching Hospitals. "Challenges in Graduate Medical Education" devoted sessions to the transition between undergraduate and graduate medical education, the quality of graduate medical education, influencing specialty distribution through graduate medical education, and institutional responsibility for graduate medical education. Twelve speakers including house officers, program directors, hospital directors, and representatives of several boards and colleges addressed various aspects of these four major topics.

The November business meeting included interim reports of the Task Force on Student Financing and the Task Force on Minority Student Opportunities in Medicine as well as reports from the Chairman and President. The work of the Task Force on Graduate Medical Education and the Task Force on the Support of Medical Education was also described. In its discussion of the program ahead, the Council reviewed the planning for its 1978 spring meeting and considered items to be presented to the AAMC Officers' Retreat.

The Administrative Board met quarterly to carry on the business of the Council, and to deliberate on all Executive Council items of significance to the deans. Much of its energy was devoted to providing guidance to and reviewing drafts of Association reports and position papers. Of particular interest was a staff paper on individual and institutional responsibilities in the conduct of industries-sponsored research and consultation. The Administrative

Board recommended that the Association's initial positions be discussed with and reviewed by organizations representing university presidents prior to the paper's release as an official Association statement. The Board also devoted special attention to the workload problems of the NIH Division of Research Grants and suggested the development of a comprehensive paper to notify the Association's constituents and governmental policy makers of the grave problems being faced by that agency.

The Council chairman initiated a new approach to assuring adequate communication between the members of the Council and its leadership. A series of small group meetings were held with deans around the country to facilitate an informal exchange of ideas and concerns. These meetings disclosed the desire on the part of many deans to be more intimately involved in the development of the Association's policies and positions. A recurring theme was the need for the Association to develop closer working relationships with university presidents and their organizations.

The Council of Deans held its spring meeting in Snowbird, Utah, continuing the tradition of an annual three-day retreat devoted to an issue of current significance. The theme of the program, "The Interface Between Government and Academic Medicine," was elaborated on by 10 speakers representing a variety of perspectives. Among the topics covered at the first session were environmental trends and economic forces affecting medical schools, efforts by the Carter Administration to revise the federal regulation writing process, the implementation of the National Health Planning Act, and local response to state and national policy initiatives.

The second day of the program was devoted to an examination of how institutions might improve their interaction with state legislators and governmental officials. The program concluded with a detailed description of the Voluntary Cost Containment Program sponsored by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals.

At the closing business session, the Council endorsed the Executive Council proposal to revise the dues structure and adopted a resolution reaffirming the deans' commitment to

affirmative action programs for recruitment and retention of qualified disadvantaged students, including minority students. Confirming the results of a recent survey, meeting participants indicated that with very few exceptions deans believed that the provision of some form of undifferentiated institutional support by the federal government should be the cornerstone of the AAMC's legislative efforts. A number of Association activities were reviewed, including the Task Force on the Support of Medical Education, a draft report on AAMC Biomedical and Behavioral Research Policy, a draft report of the Task Force on Student Financing, a draft position paper on industry-sponsored research and consultation, an AAMC response to the workload problems being encountered by the NIH Division of Research Grants, and the appointment of a new committee on technical standards for medical school admission. Other agenda items included the NBME policy of refusing to permit students from nonaccredited schools to sit for the examination unless sponsored by an accredited school, LCME's request that schools review procedures for accepting students in advanced standing, the planned meeting of the AMA Section on Medical Schools, and issues related to medical center involvement in continuing medical education.

Attendance at the meeting included 98 institutional representatives, three Distinguished Service Members, and one Canadian dean, in addition to Association staff and speakers.

### Council of Academic Societies

The Council of Academic Societies continues to grow and now numbers 60 member societies. Involvement of the member societies in the overall activities of the Association was advanced by having 18 societies designate representatives to the Group on Medical Education and by the designation of Public Affairs Representatives by additional societies. Societies were also requested to name a woman liaison officer to work with the Association's Women in Medicine program.

The CAS Services Program began its two-year experimental phase in July 1977. The Association of Professors of Medicine was the first CAS member to participate in the program. Staff to the program manage the APM's

business affairs, track issues and legislation of particular interest to departments of medicine, and prepare weekly memoranda for the APM Council and a monthly newsletter for the entire membership. The Association of University Professors of Neurology, the American Academy of Neurology, and the American Neurological Association joined to use the CAS Services Program for tracking issues and legislation and to improve the amount and currency of information provided to their members about neurological research, education and service issues.

Expanded communication with CAS societies and their members was an important activity of the Association. A twice-monthly memorandum on issues of interest to CAS Public Affairs Representatives was initiated. The quarterly *CAS Brief* increased circulation to more than 14,000 members.

At the 1977 annual meeting in Washington, D.C., Donald Kennedy, Ph.D., commissioner of the Food and Drug Administration, spoke on "The Food and Drug Administration and the Academic Medical Center." Commissioner Kennedy, after nearly a year in office, expressed his belief that the FDA and academic medical centers needed to work together to improve physician knowledge about the importance of FDA's role in drug and medical device regulation and how the FDA fulfills its responsibilities.

An interim meeting of the CAS was held in January to discuss the Biomedical Research Policy Committee's recommendations on revisions to the Association's research policy. This meeting provided for broad input into this important paper which eventually was adopted by the Executive Council.

At its meetings the CAS Administrative Board reviewed items from the Executive Council agenda and forwarded recommendations on issues of concern to faculty. These quarterly meetings also provided an opportunity for Board members to meet with representatives of the Executive and Legislative Branches for informal discussions.

### Council of Teaching Hospitals

During the past year, the Council of Teaching Hospitals held two general membership meetings. At the November 1977 AAMC annual

meeting, the Council sponsored a program on physician responsibility and accountability for controlling the demand for hospital services, with presentations reflecting three varying points of view. Robert G. Petersdorf, M.D., chairman of the University of Washington's Department of Medicine, considered the department chairman's influence in controlling the demand for hospital services, suggesting that a clinically active department chairman may be able to affect hospital costs by controlling the use of the laboratory, limiting the deployment of new medical technology, reducing the length of hospital stay, and achieving an appropriate balance between inpatient medicine and ambulatory medicine. J. Robert Buchanan, M.D., president of the Michael Reese Medical Center in Chicago and a former medical school dean, argued that unless the professional hospital staffs voluntarily lead in controlling health service costs, hospitals will face a series of progressively more damaging and restrictive regulations. Robert M. Heysel, M.D., executive vice-president and director of the Johns Hopkins Hospital, described the decentralized program of hospital management at Johns Hopkins which brought the physicians and hospital staff into more responsible management roles and enabled the hospital to contain or reduce costs in a number of areas.

In May the Council of Teaching Hospitals initiated a two-and-a-half day spring meeting to provide COTH representatives with an opportunity to personally meet and discuss problems faced by tertiary care/teaching hospitals. The meeting in St. Louis opened with a dinner address by David Kinzer, president of the Massachusetts Hospital Association, speaking on the new myths of health planning. During the general meeting session, members heard and discussed papers on the institutional responsibility for graduate medical education, hospital labor relations, and health maintenance organization/teaching hospital relationships. Following a presentation by John Affeldt, M.D., President of the Joint Commission on the Accreditation of Hospitals, members examined the particular problems faced by teaching hospitals seeking JCAH accreditation. The concluding address at the meeting was presented by Robert Derzon, administrator of the Health Care Financing Administration, who reviewed

his agency's legislative agenda and summarized his impressions and observations about the federal government and HCFA. Copies of the formally prepared papers presented at the spring meeting were distributed to all COTH members. The spring meeting was well received by the membership and plans are underway to continue this function.

The COTH Administrative Board met quarterly to develop the Association's program of teaching hospital activities. Preceding three of the Board meetings, evening sessions were held to provide seminar discussions on specific issues of concern to teaching hospitals. At the January meeting, Stewart Shapiro, M.D., and David Winston, professional staff members from the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee, met with the Board to consider upcoming proposals to review and extend the National Health Planning and Resource Development Act. Describing the collaborative process by which majority and minority staffs had met to formulate general positions for renewal legislation, Shapiro and Winston reported that Committee members favored a three year extension of the bill building upon the present planning structure. Following the presentation, COTH Board members and representatives from other AAMC Councils discussed the Association's interest and concerns about the planning legislation.

At its March meeting, the Administrative Board met with Paul Rettig, professional staff member of the Subcommittee on Health of the House Committee on Ways and Means. Mr. Rettig, whose career includes several years with the Social Security Administration and its Bureau of Health Insurance, discussed the status and evolution of cost containment legislation in the House of Representatives. He described Representative Rostenkowski's interest in stimulating voluntary cost containment and his interest in proposing "compromise" legislation which would require mandatory cost containment programs by the federal government if the voluntary cost containment program was unsuccessful. Lastly, Mr. Rettig reviewed the funding status of the Social Security Administration programs and recent legislation increasing Social Security taxes.

Dr. Petersdorf met with the Administrative

Board in June to discuss recent graduate medical education trends in internal medicine programs. Reviewing findings from the National Study of Internal Medicine Manpower, Dr. Petersdorf drew the Board's attention to the rapid increase in the percentage of internal medicine residents who follow their initial residency training with a fellowship in a medical subspecialty. Dr. Petersdorf then led a discussion of the implications of this trend for the costs of graduate medical education, the availability of general internal medicine services, and the demand for subspecialty services.

In addition to discussing and acting on all matters brought before the Executive Council of the AAMC, the COTH Administrative Board directed special attention to topics of special interest to COTH members. As required by a 1972 action of the AAMC Assembly which established the category of Corresponding Membership in COTH, the Board reviewed the membership eligibility of all present COTH hospitals and recommended that general hospitals belonging to COTH which do not have the required number or types of residency programs be reclassified as Corresponding Members. The Council also reviewed plans for and agreed to cosponsor, with the American Hospital Association and Rush-Presbyterian-St. Luke's Medical Center, an invitational conference on multi-institutional systems. After giving serious consideration to the voluntary cost containment program sponsored by the American Hospital Association, the American Medical Association and the Federation of American Hospitals, the Administrative Board supported the objectives of the voluntary cost containment program and recommended that special consideration be given to teaching hospital requirements for revenues necessary to support medical education, medical research, and tertiary care services.

### Organization of Student Representatives

In its seventh year the Organization of Student Representatives continued to serve as an effective vehicle for incorporating medical student contributions into the Association's programs and policies and for disseminating information from the Association to medical students. Membership remained at a high level, with 109

of the nation's medical schools represented. At the 1977 annual meeting students representing 85 schools attended business and regional meetings, the OSR Program entitled "A Debate on House Staff Unionization," and discussion sessions on reduced-schedule residencies and withholding of physician services. As in previous years, the OSR held regional spring meetings in conjunction with the AAMC Group on Student Affairs and the regional associations of Advisors for the Health Professions.

The OSR Administrative Board met before each Executive Council meeting to coordinate OSR proposals and activities and to formulate recommendations on matters under consideration by the Executive Council. Through its members on AAMC task forces, the OSR contributed to and learned from Association activities on graduate medical education, student financing, opportunities for minorities in medicine, and support of medical education.

An important goal of the OSR was realized this year when the Liaison Committee on Medical Education requested that the AMA Council on Medical Education and the AAMC Executive Council provide student representation to the LCME. The Executive Council approved this request, and acting on OSR recommendations, appointed a medical student to serve as a nonvoting member of the LCME for a one-year term.

During 1977-78, three issues of the *OSR Report* were published and distributed without charge to all U.S. medical students. This newsletter was initiated to improve communications between the OSR and its constituency and to apprise students of the nature and scope of the AAMC's involvement in events and issues related to medical education. The first three issues were so well received that continuation of the newsletter has been approved for an additional year.

A continuing priority for the OSR was the effort to increase the availability of information on graduate training programs. A three-pronged effort is underway: 1) coordination with the National Resident Matching Program to expand information published in the *NRMP Directory*; 2) development of a survey instrument for graduates to evaluate residencies; and 3) publication of an issue of the *OSR Report* on the residency selection process.

## National Policy

Formulating national policies for the containment of rising health care costs was a principal concern of the Carter Administration and the Congress during the past year. The Association played a significant role in the development of national cost containment policies. The Association's officers and staff also devoted considerable time and attention to amending and implementing the Health Professions Educational Assistance Act of 1976, to certain issues affecting medical school admissions, to the appropriations process and to legislative and regulatory proposals affecting biomedical research. Both the Administration and the Congress have shown a willingness to consider carefully the views of the Association in their deliberations. However, final decisions on many important issues are still pending and many may be deferred for consideration when the 96th Congress convenes.

During the past year the White House and the Department of Health, Education and Welfare (HEW) continued to press for mandatory hospital cost containment legislation as the centerpiece of efforts to control all health care costs. In April Rep. Daniel Rostenkowski, chairman of the Health Subcommittee of the House Ways and Means Committee, strongly supported primary reliance on a voluntary cost containment program for hospitals and helped mobilize Congressional support for this approach. Although a great deal of time and energy have been spent by the Congress and the Administration on cost containment legislation, final Congressional action on current legislation, which places the emphasis on voluntary measures, is anything but certain before the 95th Congress adjourns in the late fall. The association expressed its concerns to the National Steering Committee, Congressional committee staff and to the Congress that allowances should be made for increased hospital expenditures which may result from increased emphasis on hospital based ambulatory care services, costs of accrediting and operating health manpower training programs, and increases in capital and service costs related to the scope of

services provided and the patient population served by teaching hospitals.

In related action, the Department of Health, Education, and Welfare published National Health Planning Guidelines for occupancy rates in obstetrical units, minimum activity levels for open heart surgery services, service areas for megavoltage radiation therapy units and work loads for each computed tomographic (CT) scanner. The Association, while recognizing that these guidelines are intended to limit unwarranted proliferation of expensive technology, cautioned that planning guidelines and planning agencies should recognize the special needs of academic medical centers. In its testimony before the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, which was considering revision and renewal of the National Health Planning and Resources Development Act, the Association suggested the development of guidelines, as opposed to standards, and improvements and refinements in the law which would encourage a greater involvement on the part of medical educators in the planning process and prevent unwarranted intrusions into educational matters and biomedical research by Health Systems Agencies. Health care planning and the containment of health care costs will likely remain important national policy concerns for the foreseeable future.

The Association continued its efforts to amend the United States foreign medical student (USFMS) provision of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484). With the appointment of the Task Force on the Support of Medical Education, the Association began to prepare for revision and renewal of this legislation during the 96th Congress. Implementing the provisions of the current law dealing with capitation, special projects, student loans and foreign medical graduates (FMGs) were other major health manpower concerns of the Association during the past year.

The Association viewed the terms of the

USFMS capitation provision that mandated admission into U.S. medical schools of U.S. citizens studying medicine abroad as an unprecedented and unjustified intrusion of the federal government into the process of medical education and a violation of the academic freedom of the institution. Such action was also deemed unnecessary because medical schools, using their own admissions criteria, have for many years voluntarily admitted into advanced standing substantial numbers of American students who had matriculated in foreign medical schools. The Association, working with the Congress and with tremendous help from the constituency, succeeded during the latter half of 1977 in persuading the Congress to modify the most objectionable features of the USFMS provision. President Carter signed the amendment into law on December 19, 1977 (P.L. 95-215.) The modified USFMS provision requires a five percent increase in third year class size (drawing primarily from the pool of U.S. foreign medical students) as a condition for receipt of capitation funds; but schools are allowed to use their normal academic criteria in selecting students to fill these positions and to place the USFMS into either the second or third year class. As originally structured in P.L. 94-484, the USFMS was the only example of a totally unacceptable *quid pro quo* in the history of the capitation program and one with which many institutions stated they would not comply. Although initially incensed with the provision, the Association expressed its gratitude to the leadership of both Houses of Congress for their willingness to recognize inappropriate legislation and subsequently amend the law.

Problems were also encountered in implementing the provisions of P.L. 94-484 that applied to alien foreign medical graduates. These provisions were intended to reinforce U.S. self-sufficiency in the supply of physicians and to set higher standards for patient care, while allowing to a limited extent the training of foreign physicians in this country and the immigration of outstanding foreign physicians. During the spring of 1978 the U.S. State Department amended its exchange visitor (J-visa) regulations for alien physicians to clarify the status of such physicians already in training in the U.S. and to set forth regulations permitting waivers to be granted on a limited basis to

certain residency programs to avoid substantial disruption in the delivery of health services provided by the hospital.

The last area of P.L. 94-484 which proved to be bothersome was in the implementation of the Health Education Assistance Loan (HEAL) Program, designed to provide loans of up to \$10,000 per year to health professions students. As originally conceived by the legislation, this program has had little appeal to the lenders, the schools, or the students. The Association has been working, however, with the Bureau of Health Manpower to find ways to implement this loan program.

Planning for renewal and perhaps major revisions in health manpower legislation was a major concern of the Association during the last year. The Congress initially expressed its intent to reconsider health manpower legislation as a whole during the current session but, after much urging by the Association, demurred. Under the terms of the Congressional Budget Act, the Administration should submit its proposals for the renewal of health manpower legislation by May 15, 1979. In parallel with this process the Association established a Task Force on the Support of Medical Education, chaired by Dr. Stuart Bondurant, to develop recommendations and legislative specifications for the Executive Council of the Association to submit to the Congress when it formally begins to consider health manpower legislation in 1979. Considerable attention was focused on the projected physician/population ratios projected for the next 30 years and on the extent to which these forecasts should modulate medical school enrollments. The prospect was raised that in a few years the current rate of physician production would create an oversupply of physicians in this country, even without taking into account new medical schools, U.S. citizens studying medicine abroad, and foreign medical graduates.

Leaders of the Task Force and the senior staff of the Association met with key HEW personnel to discuss the Departmental initiatives related to health manpower, the most concrete of which was the Health Resources Administration (HRA) preliminary proposal. The key features of the HRA proposal focused on repealing capitation for medical schools, discouraging further enrollment increases, con-



tuining programs to correct geographic and specialty maldistribution, strengthening curriculum in priority areas, increasing minority enrollment and enhancing the productivity and competence of health personnel. In reacting to the HRA proposal AAMC representatives identified a number of concerns including the following:

1. In the opinion of the AAMC, the nation's academic medical centers have a superb record of working for the public good and are eager to continue as a partner with the federal government in the solution of the nation's health problems.

2. The complexity and the multiplicity of the interdependent functions of academic medical centers should be recognized; while undergraduate medical education *per se* is just one component of the costs of a center, sudden changes in the financing of the educational activity could have unexpected deleterious effects on the centers as a whole.

3. The diversity that currently characterizes the academic medical centers should be preserved because of the great value that accrues to the nation as a result; and

4. A very important mechanism to achieve this end—as well as a great many others—would be for the government to relate to the academic medical centers by offering economic incentives rather than by imposing restrictive and inflexible regulations.

HEW officials seemed genuinely grateful to have had the opportunity for discussion with the AAMC group and extremely interested in further interaction, particularly after preliminary proposals have been formulated by the HEW and the AAMC.

Throughout the year the Association along with the education community in general, anxiously awaited the Supreme Court decision in *Regents of the University of California v. Allan Bakke*. That long awaited decision came on June 28, when a sharply divided Supreme Court ordered the admission of Allan Bakke to the University of California at Davis Medical School, while simultaneously approving the use of race as one factor in the selection of medical students and thus giving its imprimatur to affirmative action programs. However, the Court clearly stated that any factors used in the selection process must be applied to all applicants

and that all applicants must be considered for all places in a class. In commenting on the decision, the Association stated that the principal problem for medical schools will be to find an appropriate weight for race among the many factors used in evaluating applicants. Since most medical schools are using admissions procedures consistent with the decision of the Court, there should be little effect on current affirmative action programs, other than the positive impact of removing past uncertainties. Both the AAMC and the medical schools will continue their vigorous efforts to encourage minority students to aspire to medicine as a career.

In a separate but related issue, on January 10, 1978, the U.S. Commission on Civil Rights released its Age Discrimination Study. In testimony before the Commission, the AAMC asserted and provided data showing that lesser qualifications and other non-discriminatory factors accounted for proportionally lower percentage of medical school acceptances among older applicants. The Commission's report nonetheless singled out medical schools by recommending that age should not be a criterion to determine eligibility for admission to medical and other professional schools that receive federal support. Among other things, the study also concluded that all present age discriminatory policies uncovered by the Commission are unreasonable. This conclusion constitutes an implicit rejection of the traditional "limited resources/best return on investment" argument often advanced in defense of a perceived policy of age discrimination by medical schools. The AAMC statement to the Commission mentioned this argument but did not rely upon it.

As in past years, the Association continued to monitor the federal appropriations process, particularly for its impact upon medical schools and teaching hospitals. The fiscal year 1978 appropriations process was unique because of the major controversy that developed over the use of federal funds to pay for an abortion. Because the Congress never fully resolved the issue, all Labor and HEW programs were funded under a continuing resolution for FY 78, rather than by a complete Appropriations Act. In order to pass the Continuing Resolution, the Congress was forced to reach a compromise after five months of debate. Although

not really satisfactory to either side, the abortion provision allowed the federal government to pay for the abortion of pregnancies in which the life of the mother was endangered, long lasting damage to the health of the mother would ensue or the pregnancy was the result of rape or incest promptly reported to a public health or law enforcement agency. Because the disagreement on federal funding of abortions was not resolved to the mutual satisfaction of the House and the Senate, it is likely that the FY 79 Labor-HEW Appropriations bill and perhaps other appropriations bills may be similarly delayed this year.

The first health budgets wholly developed by the Carter Administration were for FY 79. They proved austere, disappointing supporters of health professions education and biomedical research. Under the proposals of the Administration, funding for health professions education was drastically reduced, and funding for the National Institutes of Health was limited to a one percent increase. The Association worked with the Congress to increase the allocations for education, biomedical research and community health programs. As in previous years, the Association's efforts were closely coordinated with the Coalition for Health Funding. The First Concurrent Budget Resolution reflected these efforts by providing for a six percent increase for health programs other than Medicare and Medicaid. The Appropriations Committees of both the Senate and the House, staying within the limits set by the Budget Committee, substantially increased funding for biomedical research and for health manpower. Subsequently the Congress reduced funding for several HEW programs plagued by revelations of fraud or mismanagement. The Association was particularly concerned by an HEW proposal to terminate capitation funding but, with strong support from the medical schools, was able to convince the Congress not to adopt this proposal. The Association also fought for substantial increases over the Carter proposals for medical prosthetics, health services research, and general operating expenses for the Veterans Administration.

One of the principal issues of concern to the scientific community over the past year was legislation designed to regulate recombinant DNA research. Similar bills introduced into

the House and Senate provided for extension of NIH Guidelines for Recombinant DNA Research for two years, establishment of a compliance system administered by HEW, and formation of a Commission for the Study of Research and Technology Involving Genetic Manipulation. Although committee action was completed in the House, it is unlikely that legislation will be enacted in the 95th Congress because of a growing belief that the risks of recombinant DNA may have been overstated and that regulation may not be necessary at all. It would not be surprising however, if the issue reemerged in the 96th Congress because of a fear on the part of the scientific community that federal pre-emption of state and local laws might be necessary to counter the efforts of those at the state and local level that favor extremely stringent regulation. Thus, the Association has worked closely with other segments of the biomedical research community and with the Congress to develop legislation that would adequately protect public health and other life systems without unduly constraining laboratory research. The Association likewise advocated changes in the pending revisions to the Clinical Laboratory Improvement Act to exempt clinical laboratories involved solely in research and those portions of clinical laboratories that conduct routine tests solely for research purposes. That legislation has not yet become law, although enactment is anticipated.

Through an *amicus curiae* brief the Association acted to bring to the attention of the Supreme Court the possible harm to the interests of research investigators, academic institutions and the public should the Court rule adversely in *Chrysler Corporation v. Brown*, a case involving interpretation of the Freedom of Information Act (FOIA) "trade secrets" exemption. Citing the conclusions and recommendations of both the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and the President's Biomedical Research Panel, the AAMC argued that untimely disclosure of and unrestricted access to materials contained in research grant applications through the operation of the FOIA would result in the destruction of valuable property rights, undermine the effectiveness of the system for awarding grants

on the basis of scientific merit, and inhibit—and in some cases preclude—the transfer of technology from the “laboratory to the patient bedside.” Consequently, the Association urged the Court to hold that Exemption 4 of the FOIA must be interpreted as a mandatory prohibition of agency action to disclose information described therein.

The Association was also involved in a number of other important legislative and regulatory issues affecting biomedical research. Representing both the AAMC and the American Federation for Clinical Research, the Association supported Congressional action to renew the National Research Service Awards. The Association also engaged in efforts to restore the tax exempt status of research training awards; to protect and strengthen the peer review process for research grants; to reduce unnecessary federal paperwork; to adopt realistic measures for the protection of human subjects involved in research; and to establish adminis-

trative principles for health and safety research sponsored by industry and conducted in medical schools. AAMC also focused increasing attention on the activities of the Food and Drug Administration and on the Administration’s proposals to reform the drug regulation process.

The decision of Rep. Paul G. Rogers not to seek reelection and the probable assumption by Sen. Edward M. Kennedy of additional senatorial responsibilities outside the health field are certain to result in many changes for the Congressional committees dealing with health issues. The support of Rep. Rogers for medical education and biomedical research will be missed. During the coming year the 96th Congress and the Administration will be dealing with many issues of vital importance to the health of the nation. The Association will be working with them to protect and strengthen the medical education, health services, and biomedical research programs of this country.

## Working with Other Organizations

Since 1972 the AAMC has been, along with the American Medical Association, the American Hospital Association, the American Board of Medical Specialties, and the Council on Medical Specialty Societies, a member of the Coordinating Council on Medical Education. In the CCME representatives of the five parent organizations, the federal government, and the public have a forum to discuss issues confronting all aspects of medical education and to recommend policy statements to the parent organizations for approval.

During the past year the Association participated in a number of new and ongoing CCME committees addressing the continuing competence of physicians, the coordination of physician data, the future staffing of the CCME and its liaison committees, opportunities for women in medicine, the regulation of numbers and types of residency positions for foreign medical graduates, and the impact of new medical schools and issues of increasing enrollment, size and establishment of new medical schools. A CCME report submitted to the parent bodies affirmed CCME's responsibility to relate the education and training of physicians in the United States to the requirements for medical care, and CCME as well as the individual parent organizations has been working with the Department of Health, Education, and Welfare's Graduate Medical Education National Advisory Committee on issues relating to graduate medical education and specialty distribution.

The Liaison Committee on Medical Education serves as the nationally recognized accrediting agency for programs of undergraduate medical education in the United States and for the medical schools in Canada.

The accreditation process provides for the medical schools a periodic, external review of assistance to their own efforts in maintaining the quality of their education programs. Survey teams are able to identify areas requiring any increased attention and indicate areas of strength as well as weakness. In the recent period of major enrollment expansion, the

LCME has pointed out to certain schools that the limitations of their resources preclude expanding the enrollment without endangering the quality of the educational program. In yet other cases it has encouraged schools to make more extensive use of their resources to expand their enrollments. During the decade of the sixties, particularly, the LCME encouraged and assisted in the development of new medical schools; on the other hand, it has cautioned against the admission of students before an adequate and competent faculty is recruited, or before the curriculum is sufficiently planned and developed and resources gathered for its implementation.

During the 1977-78 academic year, the LCME conducted 42 accreditation surveys in addition to a number of consultation visits to universities contemplating the development or expansion of medical schools. The list of accredited schools is found in the *AAMC Directory of American Medical Education*. During the past year, the LCME awarded the status of "provisional accreditation" to four new medical schools and issued a "letter of reasonable assurance" to one two-year school to convert to a four-year M.D. degree granting program.

Two student participants, one from the AMA, and one from the AAMC, were authorized to become non-voting members of the LCME.

A number of new medical schools have been established, or proposed for development, in various developing island countries in the Caribbean area. These schools seem to share a common purpose, namely to recruit U.S. citizens. There is grave concern that these are educational programs of questionable quality based on quite sparse resources. While the LCME has no jurisdiction outside the United States and its territories, the staff has attempted to collect information about these new schools and to make such data available, upon request, to premedical students and their collegiate advisors.

The Liaison Committee on Graduate Medical Education continues to evolve its role in the

accreditation of graduate medical education. The relationship between the LCGME and the Residency Review Committees is becoming clarified, and steps have been taken to improve the information provided to both the RRC's and the LCGME about programs under review. However, significant modifications in the review and accreditation process may be required, and a subcommittee of the LCGME has been appointed to study the process and recommend changes.

Contemplating alternatives to the present policy of having the American Medical Association provide staff services, the LCGME requested that the five sponsoring organizations re-examine the original articles of agreement and negotiate the necessary changes.

A draft revision of the General Requirements for Graduate Medical Education was widely circulated during the year. Based upon comments and criticisms of that draft, a final draft will be presented to the LCGME.

The Liaison Committee on Continuing Medical Education assumed from the AMA in July 1977 the function of accrediting institutions and organizations offering programs in continuing medical education. Many of the deficiencies of the present system have been identified and corrective measures will be considered. The LCCME has begun by addressing a new definition and description of the scope and the principles of continuing medical education. AAMC members of the LCCME are actively contributing to this process and as members of the AAMC Ad Hoc Committee on Continuing Medical Education are able to apply directly the Ad Hoc Committee's findings to the deliberations of the LCCME.

The Coalition for Health Funding, which the Association helped form eight years ago, now has over 50 non-profit health related associations in its membership. A Coalition document analyzing the Administration's proposed health budget for fiscal year 1979 and making recommendations for increased funding is widely used by Congress and the press.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with members representing both the educational and professional associations of eleven different health professions. The Association staff has also worked

closely with the staff of the American Association of Dental Schools on matters of mutual concern.

The AAMC continues to work with the Association for Academic Health Centers on issues of concern to the vice presidents for health affairs. Representatives of each organization are invited to the Executive Council and Board meetings of the other.

As a member of the Board of Trustees for the Educational Commission for Foreign Medical Graduates, the AAMC expresses its interest in continuing implementation of provisions contained in PL 94-484, the Health Professions Educational Assistance Act of 1976. Under contract with the NBME the ECFMG administers the Visa Qualifying Examination developed by the NBME as the mandated equivalent to Parts I and II of the NBME examination required for foreign trained physicians by federal statute. In spite of a decline in the numbers of FMG's seeking admission to this country, the ECFMG continues to play an important role as a certifying agency, as the sponsor of the exchange visitor program, as the administrator of the VQE examination, and as a repository of valuable records.

The staff of the Association has maintained close working relationships with other organizations representing higher education at the university level, including the American Council on Education, the Association of American Universities, and the National Association of State Universities and Land-Grant Colleges. This year the AAMC worked cooperatively with these organizations as well as others in a number of areas where federal law and regulation affect higher education.

Continuous efforts have been made with the National Resident Matching Program to improve the transition from undergraduate to graduate medical education. The Association has worked closely with that organization to expand the *NRMP Directory* to provide additional information to students selecting residency training positions. Representatives of NRMP and the AAMC Task Force on Graduate Medical Education and the Organization of Student Representatives have been in frequent communication on matters of mutual interest.

The Panamerican Federation of Associations of Medical Schools is composed of organizations similar to the AAMC throughout the Western Hemisphere. In 1978 the Association hosts the Seventh Panamerican Conference on Medical Education; the theme of the Conference is "General Physicians to Meet Primary Care Needs in the Western Hemisphere."

Efforts have been made to articulate the concerns of women and document the current

status of women in medicine to concerned individuals and groups. Towards this end, the Association staff and the Women Liaison Officers have interacted with the National Coalition for Women and Girls in Education, the Women and Health Roundtable, the American Personnel and Guidance Association, the American Medical Women's Association, and Health on Wednesday, a women's governmental relations group.

## Education

During this year the medical education community has found it important on several occasions to refine its understanding and application of the concept of "educational accountability." This issue was at the basis of the 1977 Group on Medical Education (GME) Plenary Session explaining judicial reviews of faculty judgments regarding student promotion and dismissal. Two recent U.S. Supreme Court decisions involving medical schools will have significant impact on schools' decisions on academic dismissal and admissions.

Two regional meetings of the Group on Medical Education fostered expanded discussion of this concept of accountability. The Central Region reviewed performance on the National Boards as an external criterion for program evaluation. The Western GME discussed legislative incursions into medical education and their implications for legislature and faculty interactions.

Another aspect of accountability was seen in efforts of two state legislatures to place explicit restrictions on the conduct of standardized testing. As a result of these forces, the medical education community has found it essential to clarify the nature of its accountability to society, to students, and to the profession, and now perceives an obligation to participate more actively in the development of public policies.

The Group on Medical Education is continuing its discussions on this subject at national and regional levels. In addition to a further consideration of the appropriateness of National Boards for internal program evaluation, the GME is sponsoring discussions of the effectiveness of the accreditation of continuing medical education programs, the management of students with deficiencies in their professional development, and the incorporation of topical areas like nutrition and human sexuality in the medical curriculum. The membership and staff have dedicated significant effort to meeting with legislative and regulatory groups to explain the impact of their policies on educational programs.

A specific project to improve documentation

of student performance is the AAMC Clinical Evaluation Project, representing continuing Association interest in the area of personal (noncognitive) characteristics assessment. The project, which has received the support of chairmen's groups in several specialties, is a national study of the process used by faculty to evaluate the performance of students in their clerkships.

In the first phase of the project, instruments used in assessing the performance of clerks and comments regarding the evaluation process were gathered from each of the participating specialty groups. This will result in a summary statement of current evaluation practices with a special emphasis on personal qualities assessment. In the second phase of the project, small groups of clinical faculty will meet to address specific problems. In the third phase the Association will develop and distribute a handbook of suggestions for evaluation.

The New Medical College Admission Test Program is continuing interpretive studies of the new test which began its second year with the April 1978 administration. To assist admissions committees with the interpretation and use of the New MCAT, the AAMC arranged collaborative efforts for schools of medicine and undergraduate colleges. Longitudinal studies for the 1978-79 entering class are underway to address the relationship between medical school performance and New MCAT results, and descriptive studies also are being conducted on various examinee subgroups. The results of these studies will be distributed to admissions committees to augment the information in the New MCAT Interpretive Manual.

The AAMC Ad Hoc Committee on Continuing Medical Education was appointed by the Executive Council to review and make recommendations regarding the role of the AAMC in Continuing Medical Education (CME). To gain a better insight into the relationships of continuing education, physician competence and performance, and quality of patient care, the Committee participated in an AAMC re-

search project supported by the Veterans Administration. The project employed a Delphi probe of medical school faculty and practicing physicians to obtain perceptions and experiences about CME objectives and program implementation. In addition, two regional groups of the Council of Deans and a group of medical school directors of continuing medical education engaged in nominal group technique discussions about the CME role of medical schools. The Committee is using this study to prepare a final report.

The Committee also helped to plan a new project to be carried out with the Veterans Administration. This project will develop criteria and procedures for planning, implementing, and evaluating continuing education programs for health professionals involved in the Veterans Administration health care system.

The AAMC Longitudinal Study of the Medical School Graduates of 1960 focused on various medical care outcomes to better understand the dynamics of the career development process. A final report of the Study was submitted to the National Center for Health Services Research this year. The study examined the relevance of information collected earlier on members of the physician cohort and the schools they attended to eventual practice outcomes as surveyed in 1976. Findings underscored the relative importance of personal qualities of the physicians, their attitudes, interests, and preferences expressed early in medical school on career outcomes. Interest in the report has spurred the preparation of a monograph as a vehicle for dissemination of the findings.

Three-year medical programs received federal support in anticipation of a positive effect on medical manpower. An AAMC Study of Three-year Curricula in U.S. Medical Schools was completed for HEW's Bureau of Health Manpower. Eighteen schools of medicine participated in the study, representing two-thirds of all institutions conducting three-year programs in 1970-1976. As of July 1978 required three-year programs are conducted in only seven institutions, four of which propose conversion to a four-year program within the 1978-79 academic year. The study examined the process of education program change in new and old schools and the characteristics of

the resultant curriculum and educational program.

The results of the study indicate that the consideration, initiation, and presence of three-year programs during the early and middle 1970s were directly related to the financial incentives provided by the federal government. The decrease in the number of programs from the peak year of 1973 resulted, in large part, because of the diminution and eventual absence of these incentives. Although no objective differences in undergraduate academic performance were found between the students of three- and four-year programs, factors such as curriculum compression, perceived stress of faculty and students, and perceived problems with the timing of student career choices contributed to the decline of interest in the three-year programs. Furthermore, the opinion of graduate medical education program directors regarding the lesser quality of three-year program graduates had considerable effect on the relatively short tenure of three-year programs.

The nation realized 2,438 additional physicians because of the "extra" graduating classes in institutions converting from four to three-year programs. However, the return to four-year programs has lessened the impact of the bonus graduates. It is evident from the results of the study that unless enrollments are enlarged, the one-time increase in the national manpower pool will be eroded by schools returning to four-year programs.

Resource and information exchange efforts can be of significant assistance to medical faculty in the discharge of their responsibilities. The Association supports a variety of these activities as a continuing commitment to improving faculty effectiveness.

The Educational Materials Project, a continuing collaborative program with the National Library of Medicine, has continued the development of a review system for multi-media educational materials entered into the AVLINE data base. This review system engages approximately 1,400 academic experts representing the various health professions and their specialties and subspecialties. For six specialty areas collaborative arrangements have been made with specialty societies to assume some or all of the tasks involved in the review of appropriate educational materials. The re-



sults of this review are entered into the AVLINE record and include a content description of the material, a recommendation regarding its usefulness, educational format, and the most likely audience, and a critique of its contents and presentation. The AVLINE data base now contains over 6,000 entries covering the health professions disciplines, with new records being entered at the rate of about 100 per month. The AVLINE information system on multi-media educational materials has become a regular component of NLM's MEDLARS and can be accessed for searches from MEDLINE remote terminals and on-line searches from NLM. The AVLINE catalog is published on a quarterly and annual basis. Now that operational problems of AVLINE have been resolved, evaluation efforts are underway.

The Western Group on Medical Education will test the value of a Clearinghouse of Innovative Educational Projects. This idea emerged from a GME Technical Resource Panel on Medical Education Resources as a method to exchange information on interesting activities and personnel with special expertise. Utilization data will be collected to determine the value of the project as a national resource.

The GME Technical Resource Panel on the

Introduction to Clinical Medicine (ICM) submitted its final report in the form of a resource manual/compendium of ICM course descriptions, focusing on innovative and successful methods for teaching physical diagnosis. The Technical Resource Panel supplemented this report with educational exhibits and program activities at the 1977 and 1978 Annual Meetings.

Following a pilot testing of 144 students in 15 medical and public health schools in early 1977, the self-instructional International Health Course was revised and published as: *International Health Perspectives: An Introduction in Five Volumes*. Volume I concerns Worldwide Overview of Health and Diseases; Volume II, Assessment of Health Status and Needs; Volume III, Ecologic Determinants of Health Problems; Volume IV, Sociocultural Influences on Health Care, and Volume V, Systems of Health Care.

The Annual Conference on Research in Medical Education (RIME) has achieved enhanced status as a medium for information exchange during this past year, and the National Library of Medicine will begin listing papers accepted for the Conference in *Index Medicus*.

## Biomedical Research

A major undertaking of the Association during the past year was the complete re-examination of its policies in the area of biomedical and behavioral research. For several years the AAMC Executive Council has appreciated the significant changes occurring in the goals, environment, and mechanisms of support of biomedical and behavioral research. In June 1977 the Executive Council appointed an *ad hoc* committee to review AAMC's existing policy and recommend needed revisions. The committee's draft policy statement was extensively discussed at a special meeting of the Council of Academic Societies, and during the 1978 spring meetings of the AAMC Administrative Boards, Council of Deans, and Executive Council.

Following these discussions, the AAMC Executive Council approved the following goals as well as additional specific recommendations required to meet them as the AAMC policy for biomedical and behavioral research: (a) to emphasize that all levels of biomedical and behavioral research—basic, applied, and targeted—are necessary; (b) to train a sufficient number and diversity of skilled investigators to conduct biomedical and behavioral research; (c) to develop effective public involvement in the formulation of research policy; (d) to strengthen the mechanisms of reviewing and coordinating research; (e) to improve the structure and function of the institutions that perform research and those that support research so as to promote the orderly transfer of research findings to patient care; and (f) to assure adequate support for all aspects of the research process.

This document will guide AAMC representatives who present the Association's views on biomedical and behavioral research to Congress or to federal agencies.

The discussions of the *ad hoc* committee and the Boards, Societies and Councils were especially helpful because they provided a timely consensus which increased the effectiveness of AAMC comments on legislation affecting biomedical and behavioral research before Congress. Extensions of the authorities for the Cancer and Heart, Lung and Blood Institutes

were considered by Congress. AAMC supported changes which would strengthen the operation of these two Institutes and of the NIH overall while providing increased levels of funding for the Institutes.

The Association worked with other societies to support the amendment and extension for three years of the authority for the National Research Service Awards Act (NRSA), the only authority under which research training may now be conducted by NIH and ADAMHA. The Office of Management and Budget (OMB) continued to oppose federal support of research training, and proposed to phase out the institutional research training grant programs beginning in fiscal year 1979. However, both the House and the Senate have been persuaded to accept the principle that at least 50 percent of training awards made by NIH and ADAMHA must be made as institutional training grants. Such a requirement has now been written into the law, thus assuring such grants for at least three years.

In the area of federal funding of research the year began on an encouraging note with both the President and the Congress calling for increased funding of basic research. However, the federal biomedical research budget proposed for fiscal year 1979 was less than needed to keep pace with inflation. When these inconsistencies of purpose and reality were explained to the Congress, the Congress added sufficient funds to make an increase in basic research funding possible, only to remove the funds subsequently in response to the California "taxpayer revolt."

For many years the first \$3,600 to \$3,900 of federal research training awards has been excludable as income for tax purposes. In September 1977 the Internal Revenue Service ruled informally that research training stipends made under the 1974 National Research Service Award Act were taxable. The Association, through its legal counsel, protested this ruling to no avail. When the situation was explained to key Congressmen, legislative provisions were introduced to restore the tax exclusion.

Government regulation of biomedical research was of particular interest to the Association as the Congress considered bills that would place major restraints upon the scientific research community. Concern over the potential dangers to public health and the environment of recombinant DNA research produced a flurry of proposals which would have severely restricted the ability of scientists to conduct such research. The Association, along with other scientific organizations, was greatly distressed by the content of these bills, and communicated its conviction that it was inappropriate for the Congress to attempt to regulate research by statute except in the face of the clearest potential for danger, and further attempted to demonstrate that the potential benefits of recombinant DNA research had been understated while the potential hazards had been overemphasized. The Association asked that the NIH guidelines on recombinant DNA

research, previously applied only to federally-financed research, be adopted as the national standard for all research in this area, and also strongly opposed the establishment of a free-standing national commission charged with regulating this research.

Through a combination of factors, the Association became aware that the NIH peer review system had come under severe stress. In less than 10 years the number of applications being processed had doubled while the scientists and administrators charged with review of applications had remained constant or even declined. The causes of this situation and some possible remedies were studied by the Association and brought to the attention of members of the Executive and Legislative Branches. The Association continues its efforts to support the peer review system which has served the biomedical research community so well.

## Health Care

The organization of ambulatory services remained an issue of primary concern to teaching hospitals, many of which are planning or have recently completed facility construction and/or programmatic restructuring. In early 1978 the AAMC completed a workshop program, supported by the Health Resources Administration of the Department of Health, Education and Welfare, to develop improved ambulatory care programs in teaching hospitals. The final report of that program provides a descriptive analysis of the various organizational models used by participating institutions and suggests methods by which certain institutional characteristics may be modified to achieve more efficient, financially independent ambulatory care programs. Those programs organized around a strong, well integrated faculty practice plan appear to be making the greatest progress toward a goal of self-sustaining one-class systems with diversity in undergraduate and graduate education.

Education of future health practitioners in the complexities of quality assurance and cost containment has become a goal of increasing importance for the Association and its constituents. Support from the National Fund for Medical Education has allowed the AAMC to sponsor a series of workshops on this issue for teams from twenty-two institutions. The final product of this effort included an outline of a "primer" for faculty and students on the essential elements of a comprehensive program of quality measurement, quality assurance, and related cost containment strategies. The complete text will include chapters on basic elements of quality assurance and cost containment programs adaptable to institutional or

individual practice situations, the present state of the art in the undergraduate and graduate medical education efforts, strategies for developing programs within academic institutions, and methods for evaluating the impact of such programs.

As a further step in the development of comprehensive programs to introduce medical students and residents to the principles and strategies of health care cost containment, the AAMC plans to use results from its survey of cost containment programs in medical schools to provide the basis for a clearinghouse of information for interested constituents, and a baseline from which to plan strategies for the national development of such programs.

A major element of any quality assurance program must be continuing education related to the performance and quality of the care rendered by health professionals. Thus, the profession and the public need to be confident of the quality of learning opportunities designed to improve the performance of physicians and other health professionals. During the coming year the AAMC will work with the Veterans Administration to develop a system to evaluate continuing education programs, including the development of standards and criteria based on adult-directed learning concepts. Detailed guidelines suitable for applying these principles to continuing education systems and the development of a management information system necessary for ongoing evaluation will be parts of the collaborative work program effort. It is expected that these various elements developed within the VA system will be applicable to any continuing education program.

## Faculty

During the past year the Association completed a series of national workshops in faculty development, tested a clearinghouse on innovative educational projects, and developed a series of videotapes on the teaching of interpersonal skills. In addition, the Final Report of the Faculty Development Survey was completed and distributed to each medical school.

In mid-1978 the activities of the Association's faculty development program were transferred to the new National Center for Faculty Development at the University of Miami School of Medicine. The Association and the program's sponsors, the Kellogg Foundation and the Commonwealth Fund, agreed that the University's ability to serve as a "living laboratory" for faculty development activities would provide an appropriate base for continuing the educational programs established during the past four years at the Association.

The Faculty Roster System, initiated in 1965, continues to provide valuable information on the key resource for medical education—the faculty. This data base maintains demographic, current appointment, employment history, credentials and training data for all salaried faculty at U.S. medical schools. This system includes providing medical schools with faculty data in an organized and systematic manner to assist the schools in their activities requiring faculty information. These activities include completion of questionnaires for other organizations, the identification of alumni now serving on faculty at other schools, and special reports which display faculty data by differing sets of variables.

This data base has also been used for a variety of manpower studies, including an annual report, third in a series, entitled *Description of Salaried Medical School Faculty 1971-72 and 1976-77*. These studies were supported by a contract with the Bureau of Health Manpower, and contain summary information on faculty appointment characteristics, educational characteristics, employment history, and various breakdowns by sex, by race and ethnic group, for foreign medical graduates, and for

newly hired faculty. A companion report is underway this year, supported by a contract with the National Institutes of Health, which will contain 1977-78 data on salaried medical school faculty.

As of June 1978, the Faculty Roster contained information for 48,586 faculty. An additional 24,002 records are maintained for "inactive" faculty, individuals who have held a faculty appointment during the past twelve years but do not currently hold one.

Six workshops were held during the past year to inform school personnel of revised reporting forms and procedures and to increase participation in the system. There is a continual effort to improve services to the schools and, through their active participation in the Faculty Roster, to maintain complete and current information on their faculty.

The Association's 1977-78 Report on Medical School Faculty Salaries was released in March 1978. As a result of several pilot studies, the treatment of nature of employment was changed. It had been evident for some time that the conventional definitions of strict and geographic full-time infrequently conformed exactly to institutional practice. This year the schools were asked to report the designations used by the schools themselves and a portion of the Report reflects this request. An analysis was also included, however, of salary data conforming to the definitions from earlier studies. The data collection instrument focuses on the individual salary components as they combine to reflect total compensation.

Compensation data were presented for 108 U.S. medical schools and covered 23,530 filled full-time faculty positions. The decrease from last year's level of participation is attributable to the more rigorous elimination of incompletely reported salaries. The tables present compensation averages, number reporting and percentile statistics by rank and by department for basic and clinical science departments. Many of the tables provide comparison data according to type of school ownership, degree held, and geographic region as well.

## Students

Approximately 36,000 applicants filed more than 300,000 applications for first year places in the 1978-79 entering classes of U.S. medical schools, a 10 percent decline in applicants from the previous year. The quality of the applicants remains high, and there are still more than two candidates for each available place. Medical school enrollments continue to rise, and the 16,136 freshmen and 60,039 total students reported by the nation's medical schools for 1977-78 constitute an all-time high.

The application process was assisted by the Early Decision Program and by the American Medical College Application Service (AMCAS). For the 1978-79 first year class 816 students were accepted at 61 medical schools participating in the Early Decision Program. Since each of the 816 students filed only one application compared to the average of 9 applications, the processing of about 6,500 multiple applications was eliminated.

Eighty-nine medical schools use AMCAS to process first-year application materials. Besides collecting and coordinating admissions data in a uniform format, AMCAS provides rosters and statistical reports to participating schools, and maintains a national data bank for research projects on admissions, matriculation, and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Student Affairs Steering Committee.

The 1978 entering class of students was the first admitted using performance on the New Medical College Admission Test (New MCAT) as part of the evaluation process. Examinees in 1977 numbered 56,658. In the spring of 1978, a total of 27,331 examinations was administered, a 10 percent decrease from the spring of 1977. The AAMC, in cooperation with selected undergraduate colleges and schools of medicine, is studying the new test to facilitate the use and interpretation of score performance by students, advisors, and admissions committees. Under AAMC direction, the American College Testing Program continued responsibility for

operations related to the registration, test administration, test scoring and score reporting for the New MCAT.

In response to concerns on the part of a variety of members of the medical education community over the increasing financial problems of medical students, a Task Force on Student Financing was created in 1976 to examine existing and potential mechanisms for providing financial assistance to medical students. The Task Force report addressed the need to eliminate financial barriers for students seeking a medical education, to keep student borrowing at reasonable levels, to continue an adequate federal loan program and necessary financial aid counseling, and to assure that each medical school uses a variety of strategies suited to that institution to provide student financing.

There have been several AAMC activities and publications to increase opportunities for minority students in medicine. Foremost among these has been the Simulated Minority Admissions Exercise (SMAE), first developed in 1974 and recently broadened to include new types of simulated cases. The purpose of SMAE is to train admissions committee members to assess the potential for medicine of minority applicants. Trainees review simulated applicant data including grades, test scores, and noncognitive information. SMAE workshops have been presented at 25 medical schools and to preprofessional advisors. By request, presentations have also been made to representatives from schools of pharmacy, optometry and osteopathic medicine.

*Minority Student Opportunities in United States Medical Schools*, updated in 1977, is available for prospective medical school applicants, admissions officers, and premedical advisors. This publication provides detailed information about medical school programs of recruitment, admissions, academic reinforcement, and financial aid available to disadvantaged students. It also includes data on minority group graduates. The Medical Minority Appli-

cant Registry, circulated to all U.S. medical schools, assists schools in identifying minority and financially disadvantaged candidates seeking admission to medical school.

The AAMC Task Force on Minority Student Opportunities in Medicine submitted its final report to the Executive Council. The report presented recommendations to increase the participation of underrepresented minority groups in medicine. During its deliberations, the Task Force solicited input from premedical advisors, medical school faculty, administrators and students, and other individuals and researchers who have studied the issues and problems affecting the participation of underrepresented minority group members in medicine.

A major program focusing on minorities in medical education is sponsored annually during the AAMC annual meeting. The 1977 program featured Dr. Charles E. Odegaard, President Emeritus of the University of Washington, who discussed the efforts of the medical schools over the past decade to increase opportunities for members of minority groups.

The Group on Student Affairs-Minority Affairs Section (GSA-MAS) held its first formal meeting at the 1977 AAMC annual meeting. The GSA-MAS will serve in an advisory and resource capacity to the Association on issues related to minority students. The section has representation from all U.S. medical schools.

During the year, eight major student studies were completed under contract with the Bureau of Health Manpower (BHM). Three dealt with the admissions process, one with enrolled students, one with graduating seniors and three with medical school financing.

The *Descriptive Study of Medical School Applicants, 1976-77* included new data on size of hometown which showed that 41 percent of applicants were from localities with populations under 50,000 and 52 percent anticipated establishing practices in areas of this population size. An *Analysis of the Admissions Process to U.S. Medical Schools, 1973 and 1976* confirmed that recent efforts to increase the acceptance of women and minority group applicants were successful but revealed that most admissions committees do not emphasize the future career plans of applicants. The *Trend Study of Coordinated Transfer Application Sys-*

*tem (COTRANS) Participants, 1970 Through 1976* revealed that the overall trend in advanced standing admissions and performance on Part I of the National Board Examinations was up from 1970 through 1975 but plateaued in 1976. Half of COTRANS participants are from families with annual incomes over \$20,000 and over a fifth have "physician" fathers compared with about 12 percent for regular applicants.

The *Descriptive Study of Enrolled Medical Students, 1976-77* provides a detailed picture of the characteristics of the 58,000 enrollees, and shows a continued trend toward interest in general/primary care. Forty percent of the first-year students had preadmission career choices in this area compared with 31 percent of final-year students.

The study of *Feasibility of Incorporating Graduation Data Into AAMC's Medical Student Information System* led to the initiation of the first national survey of graduating seniors. Annual administration of this seven-page questionnaire will permit trend analyses of student experiences in medical school, plans for graduate medical education, and ultimate plans for career specialty and geographic location.

Reports on medical student financing included *Comparisons of 1974-75 Survey Findings with Data from Other Sources* showing that the national surveys of individual students are needed to supplement aggregate data provided by medical school financial aid officers. *Proposed Plans (and Questionnaire) for Identifying Factors Inhibiting Medical Students from Applying to the NHSC Scholarship Program* outlined a plan aimed at making NHSC scholarship programs more appealing to future medical students. The methodology used in national AAMC surveys of medical education financing is included in *Proposed Methodology for Future Surveys of Medical Student Financing*.

Three efforts concerned with Women in Medicine are underway. The first concerns an analysis of the differing acceptance rates of women at medical schools to determine the characteristics of institutions with high percentages of women medical students. The second study is an effort to determine if women medical students obtain their choice of specialty and residency program with the same

degree of success as male medical students. It is anticipated that an analysis of the AAMC Graduation Questionnaire and the NRMP data will be conducted for that purpose. The AAMC, in cooperation with Wellesley College, presented a day long Women in Medicine

Workshop for Wellesley College Pre-medical students and advisors. Because of the success of the workshop, funding is being sought to replicate the workshop to develop educational materials for all female college students interested in a career in medicine.



## Institutional Development

Now in its sixth year, the AAMC Management Advancement Program offers a variety of management development opportunities for medical school administrators. Originally designed as an educational program for medical school deans, the program audience has expanded to include department chairmen and hospital directors.

The MAP encompasses several kinds of activities, all designed to facilitate effective decision-making in the academic medical center complex. In the Executive Development Seminar or Phase I, medical school deans, department chairmen or hospital directors discuss common administrative problems while acquiring a basic working knowledge in planning and control and behavioral science concepts. Lectures and discussion sessions provide an opportunity for consideration of management technique and theory.

Institutional Development Seminars or Phase II encourage the generation of problem-solving plans by small teams of institutional representatives. Medical school deans who have participated in a Phase I session are invited to identify an institutional issue requiring careful study. Each dean then selects a group of individuals from the medical center involved in the implementation of actions taken on the issues being addressed. Each school team is assigned a management consultant responsible for facilitating the work of the group and for suggesting alternative approaches to the particular issues being considered.

The third part of the Management Advancement Program is the Technical Assistance Program (TAP). TAP provides follow-up assistance to Phase I and Phase II participants, including administration of seminars designed around specific management topics, identification of individuals or teams of individuals who can provide management consultation on site at medical center locations, and design and implementation of studies to document management issues and/or techniques of particular relevance to academic medical center decision makers. For example, as a part of the TAP, a

seminar on financial management will be offered to medical school deans in the fall of 1978.

The MAP has been both an educational effort and an opportunity for senior administrators from academic medical centers to develop institutional plans. All medical school deans are invited to attend, and since 1972, 112 deans, 69 hospital directors and 48 department chairmen have participated in Executive Development Seminar sessions. Institutional Development Seminars have included 70 institutions, 25 of which have attended Phase II more than once. More than 727 individual participants have attended MAP seminars, including deans, department chairmen, hospital directors, vice presidents, chancellors, program directors, business officers, planning coordinators, trustees, and state legislators.

The Management Advancement Program was planned by an AAMC Steering Committee chaired by Dr. Ivan L. Bennett, Jr. This Steering Committee continues to participate in program design and monitoring. Faculty from the Sloan School of Management, the Massachusetts Institute of Technology, have played an important role in the selection and presentation of seminar content. Consulting expertise has been supplied by many individuals, including faculty from the Harvard University Graduate School of Business Administration, the University of Oklahoma College of Business Administration, the Brigham Young University, the University of North Carolina School of Business Administration, and the George Washington University School of Government and Business Administration. Initial financial support for the program came from the Carnegie Corporation of New York and from the Grant Foundation. Funds for MAP implementation and continuation have come primarily from the Robert Wood Johnson Foundation; in addition, conference fees help to meet expenses.

The Management Advancement Program has stimulated requests from academic medical center administrators for access to management information on a regular basis. In addition,

requests for program participation have been greater than can be accommodated in a limited number of Phase I and Phase II sessions. In response to these demands, the Management Education Network Project was designed to identify, document and disseminate to a broad audience management theory and techniques specifically applicable to the academic medical center setting. Supported by the National Library of Medicine, this project focuses on four tasks: (a) regular review of the management literature for books and articles of relevance for the MAP audience. Quarterly publication of an annotated bibliography, "MAP Notes," keeps those on the mailing list abreast of new information about management practices and procedures; (b) development and review of audiovisual instructional materials based on selected aspects of Phase I contents; (c) documentation of medical center experiences with specific reference to management issues or practices. In this area, an extensive case study on the use of Departmental Review in Medical Schools has been completed and distributed;

(d) design and implementation of a simulation model to be used for projecting implications of academic tenure policies under each of several circumstances. The emphasis in this area is to develop a viable model and to demonstrate the capabilities of simulation modelling as a management tool.

In the past year the Visiting Professor Emeritus Program with support from the National Fund for Medical Education has established a roster of active senior physicians and scientists in diverse specialty areas, and has encouraged medical schools to participate in the program whenever temporary faculty assistance is needed. These goals are being realized and visits to medical schools by emeritus professors frequently occur. As a result, the Association is now considering additional ways to utilize the talents of experienced medical educators. It is hoped that the program can continue to be a worthwhile service to the medical schools as well as providing new opportunities for senior professors to contribute in areas where their skills are greatly needed.

## Teaching Hospitals

The Association's teaching hospital activities for 1977-1978 focused heavily on six topics: proposed federal actions to restrict hospital revenues for patient services; Medicare regulations governing payments for teaching physicians; proposals to extend, amend, and implement the National Health Planning and Resource Development Act; legislative and legal challenges arising from the National Labor Relation Board's finding that house staff are students for purposes of the National Labor Relations Act; major revisions in the governance and management sections of the accreditation manual of the Joint Commission on the Accreditation of Hospitals; and proposed changes in hospital accounting for related organizations and funds held in trust by others.

In the spring of 1977 the Carter Administration proposed legislation to limit hospital revenues and capital expenditures. The Administration's proposal and several competing proposals were widely debated and considered during the past year. In addition to testifying before four Congressional subcommittees on cost containment last year, the Association worked with congressional staff on issues of particular concern to tertiary care and teaching hospitals.

In response to charges that his Medicare-Medicaid reform bill did not address all payors and hospital charges, Sen. Talmadge announced an expanded version of the bill which would limit routine service revenues on a per diem basis and ancillary service revenues on a per admission basis. At hearings held to obtain initial reaction to the Talmadge proposal, the Association—while supporting several principles in the proposed bill such as the effort to recognize differences among institutions and geographic regions and the effort to exclude uncomparable or uncontrollable costs when comparing institutions—expressed concern about: the classification system for grouping hospitals, the price indexes for calculating ancillary service limits, the lack of a definition for "revenue," the absence of a method for incorporating excluded routine service costs into the

revenue limit, and the question of whether special care units would be treated as ancillary or routine services. Lastly, the AAMC cautioned against establishing a long-run approach to hospital payment which would fragment hospital management and operations by calculating separate revenue centers for individual routine and ancillary service costs.

Later in the year Chairman Dan Rostenkowski of the Subcommittee on Health of the House Ways and Means Committee challenged the American Hospital Association, the American Medical Association, and the Federation of American Hospitals to initiate and organize a program to restrain cost increases in hospitals. As a result of the Rostenkowski challenge, the three organizations organized a voluntary cost containment program under the direction of a National Steering Committee for Voluntary Cost Containment which adopted a fifteen-point program for voluntary hospital cost containment. The Association's Executive Council supported the overall objective of voluntary cost containment but expressed concern that the fifteen-point program of the National Steering Committee failed to make allowances for increased hospital expenditures resulting from increases in the number and availability of ambulatory care services, large number of hospital-based physicians, costs for accredited manpower training programs, and the impact of a hospital's scope of services and patient mix.

In 1975 the Association filed suit in the U.S. District Court for the District of Columbia seeking relief from the regulations implementing Medicare routine service payment limitations imposed by Section 223 of Public Law 92-603. Following a District Court decision upholding the regulations, the Association appealed the case, but the Court of Appeals for the District of Columbia dismissed the Association's Section 223 challenge for lack of jurisdiction. The Court held that the AAMC had failed to exhaust its administrative remedies because the Association, through its teaching hospitals, had not presented a claim to the

Provider Reimbursement Review Board for what it believed to be appropriate reimbursement for teaching hospitals. While the Court of Appeals' opinion did dismiss the Association's challenge, it had the potential beneficial effect of vacating the District Court decision upholding the regulations implementing Section 223. In addition to the legal challenge of Section 223 regulation, the Association has objected annually to the proposed Section 223 limitations because they fail to adequately recognize the increased costs of teaching/tertiary care hospitals and fail to establish explicit exception criteria for hospitals with atypical costs.

Section 227 of the 1972 Social Security Act Amendments included Medicare modifications for "payments for the professional medical services of physicians rendered at teaching hospitals." Implementation regulations originally proposed in 1973 were withdrawn by the government. HEW then recommended to Congress that the implementation of Section 227 be delayed, and Congress responded by delaying implementation until October 1, 1978.

Throughout the past year staff of the Health Care Financing Administration have worked to develop proposed regulations implementing Section 227. The Association has monitored these activities and assisted in developing and evaluating potential regulatory language. In addition, the Association obtained a commitment from Health Care Financing Administrator Robert Derzon to have at least one comment session on the proposed regulations prior to their publication in the *Federal Register*. The comments session, involving faculty, deans, and teaching hospital representatives from the Association, was held in early April using an early and preliminary draft of the 227 regulations. At this writing, the Association remains prepared to review, distribute, and organize comments on the 227 regulations when they are officially published in the *Federal Register*.

During the past year proposed legislation to renew the National Health Planning and Resource Development Act and regulations implementing the original act have received substantial attention from the Association. Last year, the Association asked Eugene J. Rubel, former Acting Director of Bureau of Health Planning and Resource Development, to study the participation of medical schools and teach-

ing hospitals in the national health planning program. Mr. Rubel's report, based on site visits in seven cities summarizing the involvement of AAMC constituents in the planning process, was widely distributed within the Association for comments and evaluation.

The Association testified before the House Subcommittee on Health and the Environment on proposed legislation to review and renew the national health planning act. The Association's testimony favored provisions of the proposed bill to extend certificate of need to non-institutional providers, to increase federal funding for health planning, to permit planning in agencies to carry over funds from one year to the next, and to prevent individuals serving on Health Systems Agencies (HSAs) in both their place of residence and employment. AAMC recommended that institutional health service proposals be encouraged to address their impact on the clinical needs of medical education and biomedical research programs; that HSA review and approval for federal funds be eliminated for manpower and research grants; that HSAs be permitted to approve the limited introduction of new technologies prior to the development of planning guidelines; that HSAs be prohibited from conditioning approval of one health service on an institution's agreement to develop a second health service; that Congressional intent on health planning guidelines be clarified to indicate that guidelines are advisory not mandatory; and that HSAs and State Health Coordinating Councils be required to include a medical school dean, in areas with a medical school, and the chief executive officer of a tertiary care/referral hospital. Similar health planning recommendations were advocated in a statement submitted to the Senate's Subcommittee on Health and Scientific Research.

HEW published three proposed planning act regulations of interest to Association members this year. Draft regulations proposing national guidelines for health planning were criticized by the Association for failing to accommodate the unique role of academic medical centers and teaching hospitals, for inadequate exception procedures, for rigidity and arbitrariness, for the questionable way in which numerical standards were derived, and for failing to specify that the guidelines are advisory, not man-

datory. The Association's response also contained detailed comments and suggestions for each of the eleven guidelines proposed.

HEW also published draft regulations concerning Health System Agencies' review of proposed uses of federal funds. In commenting on these draft regulations, the Association encouraged HEW to recognize the confidentiality of research grants and contract proposals, requested clarification of HSA responsibilities for federally-funded projects impacting on more than one health service area, requested additional clarification on provider responsibility for periodic reports to health service agencies, urged HEW to establish dollar thresholds below which HSA review would not be required, and requested clarification of the special consideration for projects meeting the needs of minorities, women and the handicapped.

HEW also published proposed regulations for Health System Agency and state agency review of existing and new institutional health services. In comments on the proposed regulations the Association cited a study by the Orkand Corporation to suggest that HSAs would be over-taxed by the imposition of the proposed program review activities. The Association also cited the failure of the proposed regulations to consider the special needs and circumstances of medical education in the development of appropriateness review criteria, requested additional provisions for provider participation and appeal mechanisms as a part of the review process, urged that the appropriateness review be treated as a planning rather than a regulatory function, and urged adding provisions to encourage state agencies to utilize existing information sources rather than to create additional sources of information.

A 1976 decision by the National Labor Relations Board (NLRB) declaring that housestaff are primarily students rather than employees for purposes of the National Labor Relations Act continues to involve the Association in both legislative and judicial actions. Early in 1977 Representative Frank Thompson, Jr., introduced legislation overturning the NLRB decision by defining housestaff as employees for purposes of the National Labor Relations Act. During the past year the Thompson bill has been approved by the full House Committee on Education and Labor and cleared for floor

action by the House Rules Committee. The Association continues to work with Congressmen who are opposed to legislation which would mandatorily define housestaff as employees and impose an industrial labor relations model on graduate medical education programs.

In related court actions, the Association submitted *amicus curiae* briefs in two cases in which the Physicians National Housestaff Association (PNHA) sued the National Labor Relations Board. In the first case, the Court of Appeals for the Second Circuit ruled that the jurisdiction of the NLRB preempted state labor boards from asserting jurisdiction over housestaff. In a separate case PNHA alleged that the National Labor Relations Board had exceeded its authority in the Cedars-Sinai decision; however, the suit was dismissed for lack of jurisdiction by the U.S. District Court for the District of Columbia. PNHA is attempting to appeal the dismissal and the Association continues to monitor court activities of this suit.

The Joint Commission on the Accreditation of Hospitals circulated proposed revisions for the governing body and management sections of a revised *Accreditation Manual for Hospitals*. To prepare the Association's comments on the revision, copies of the proposed section were sent to a sample of COTH Chief Executive Officers selected to represent different types of teaching hospital ownership, affiliation, and specialty. On the basis of membership comments, the Association submitted an extensive review of the proposed manual to the Joint Commission. In addition to particular concerns with specific JCAH recommended standards and interpretations, the Association expressed concern that the draft standards were an overly specific, cookbook approach to governance and management and that they failed to address the particular governance structures of university-owned and public hospitals. The Association continues to review revised drafts for the manual.

In February the Subcommittee on Health Care Matters of the American Institute of Certified Public Accountants (AICPA) proposed new hospital reporting practices for related organizations and for funds held in trust by others. Abandoning the existing principle that

combined financial statements should be prepared for related organizations controlled by the hospital, the AICPA's proposal advocated combined financial statements for the hospital and for "resources handled by an organization separate from the hospital . . . if, in substance, (resources) use for eventual distribution were limited to support activities managed by, or otherwise closely related to, the hospital." The Association testified before the AICPA Subcommittee, objecting to the proposed reporting policy. The Association strongly recommended retaining control as the primary determinant of reporting requirements and suggested eight criteria for developing reporting guidelines and four types of control relationships. The Association continues to follow the activities of the AICPA and has asked to testify on any revised draft recommending reporting procedures for

related organization funds and for funds held in trust by others.

The Association's program of teaching hospitals surveys combines four recurring surveys with special issue-oriented surveys. The regular surveys are the Educational Programs and Services Survey, the House Staff Policy Survey, the Income and Expense Survey for University-Owned Hospitals, and the Executive Salary Survey. The findings of these surveys are furnished to participating hospitals and, when appropriate, results have been publicly distributed. One special survey, the COTH Survey of Physical Plant and Capital Equipment Expenditures Required to Meet JCAH Standards, was conducted during the past year. Information from the 1977 survey will accompany a new survey to be submitted to the COTH membership in the upcoming year.

## Communications

The Association employed a variety of publications, news releases, news conferences and personal interviews with representatives of the news media to communicate its views, studies and reports to its constituents, interested federal representatives, and the general public.

Perhaps the largest news story to occur this year affecting the Association and its member medical schools was the U.S. Supreme Court decision in *The Regents of the University of California v. Allan Bakke*. The AAMC responded to news media inquiries shortly after the Court handed down the decision with a short statement and then after the decision had been analyzed, held a news conference which received extensive media coverage.

The major means by which the Association informs its constituents of federal and AAMC happenings is the President's *Weekly Activities Report*, which reaches more than 9,000 individuals 43 times a year. This *Report* covers events that have a direct effect on medical education, biomedical research, and health care.

In addition to the *Weekly Activities Report*, other newsletters of a more specialized nature are: The *COTH Report*, which has a monthly circulation of 2,400; the *OSR Report*, circulated three times a year to all medical students; and *STAR* (Student Affairs Reporter), which is printed four times a year with a circulation of 900. The *CAS Brief*, a quarterly newsletter begun in 1975, is prepared by the staff of the AAMC Council of Academic Societies and is distributed to individual CAS members

through the auspices of the individual societies. Reporting on major public policy issues of particular interest to medical school faculty, the *CAS Brief* now reaches 14,000 readers.

The Association's *Journal of Medical Education* received a Distinguished Achievement Award from the Educational Press Association of America for "excellence in educational journalism."

In fiscal 1978 the *Journal* published 1,034 pages of editorial material in the regular monthly issues, including 173 papers (83 regular articles, 75 Communications, and 15 Briefs). The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine. Monthly circulation averaged about 6,700.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1977-78 totaled a record 429; 139 were accepted for publication, 201 were rejected, 11 were withdrawn, and 78 were pending as the year ended.

About 32,000 copies of the annual *Medical School Admission Requirements*, 3,500 copies of the *AAMC Directory of American Medical Education*, and 6,000 copies of the *AAMC Curriculum Directory* were sold or distributed. Numerous other publications, such as directories, reports, papers, studies, and proceedings also were produced and distributed by the Association.

## Information Systems

The Association has continued to expand the scope and increase the content and utility of the information systems which support its activities. These systems are now almost entirely on an inhouse computer system and the AAMC staff has available major data systems for students, faculty, and institutions.

Primary among the student information systems is the American Medical College Application System. This system supports the Association's centralized admission system by maintaining data on applicants to medical school. Products from this system are sent to medical schools and applicants on a daily basis, and rosters of applicants and summary statistics are sent to the schools periodically. In addition, the applicant information is available to Association personnel on an immediate basis for responding to telephone inquiries from both medical schools and applicants. The AMCAS system also generates a number of special reports throughout the year, and the data are used to answer specific questions which arise from schools or the Association staff. The information maintained in the AMCAS system is used as the basis for the Association's annual descriptive study of medical school applicants.

There are a number of other data systems that support the AMCAS system and provide information for the admissions process. Among these systems are the New MCAT Reference System, providing information on the New MCAT scores and questionnaire responses of applicants; the College System of information on all colleges in the United States; and the Coordinated Transfer Application System (COTRANS) of records of U.S. foreign medical students applying to U.S. medical schools.

Other data systems have been created to support the Association's research on students. These include systems to process information obtained from the Graduation and Financial Aid Questionnaires, both of which were in the field in early 1978.

Work is currently in process on the conversion of the remaining student information systems to in-house operation. The major devel-

oping system is the enrolled medical student information system, which will become the central repository of information on medical students and will establish a career development database to follow medical school graduates into practices. In concert with the creation of the enrolled medical student information system, work is underway to facilitate historical and comparative studies of medical school applicants, medical students, and medical school graduates.

The Association maintains two major information systems on medical school faculty: The Faculty Roster System and the Faculty Salary Survey Information System. The Faculty Roster System has undergone a major conversion in the past year and currently exists on an on-line system for research focused on medical school faculty. The Faculty Roster System includes information on the background, current academic appointment, employment history, education and training of all salaried faculty at U.S. medical schools. Medical schools benefit from the reports from the system presenting data on faculty in an organized and systematic manner. Data from the Faculty Roster also have formed the basis for an annual descriptive study of salaried medical school faculty for the past three years.

The Faculty Salary Survey System is used to generate annual reports on medical school faculty salaries. The information is also available on a confidential, aggregated basis in response to special inquiries from schools.

The Association supports a number of information systems on institutions, the predominant being the Institutional Profile System, a repository for information on all medical schools. The data base is supported by a computer software package that allows immediate user retrieval of data from remote terminals to respond to requests for data from medical schools and other interested parties, as well as to support a variety of in-house research projects. In the past year, IPS has responded to 200 requests for information and has supplied data for a number of studies including *Institutional*



*Characteristics of U.S. Medical Schools: 1975-76*, and a series of studies describing medical education institutions prepared for the Bureau of Health Manpower, Department of Health, Education, and Welfare.

The Association has developed an ancillary system to the Institutional Profile System to process Part I of the Liaison Committee on Medical Education Annual Questionnaire. This system generates reports which compare the data for the current year with those reported

in previous years.

Institutional data on teaching hospitals are also maintained. Annual surveys are conducted to obtain national information on housestaff stipends, benefits and training agreements, income, expenses, and general operating data for university-owned hospitals; hospital and departmental executive compensation; and general operating, educational program, and service characteristics of teaching hospitals. This mass of information serves as the basis for a number of Association publications.

# AAMC Membership

	TYPE	
	1976-77	1977-78
Institutional	115	115
Provisional Institutional	3	6
Affiliate	17	16
Graduate Affiliate	1	1
Academic Societies	60	60
Teaching Hospitals	400	399
Corresponding	4	8
Individual	1,944	1,824
Distinguished Service	43	44
Emeritus	71	70
Contributing	6	6
Sustaining	12	11

## Treasurer's Report

The Association's Audit Committee met on September 13, 1978, and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1978. Meeting with the audit committee were representatives of Ernst & Ernst, the Association's auditors; the Association's legal counsel; and Association staff. On September 14, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled \$8,909,319. Of that amount \$6,473,624 (72.66 percent) originated from general fund sources; \$648,528 (7.28 percent) from foundation grants; \$1,736,663 (19.49 percent) from federal government reimbursement contracts; and \$50,504 (.57 percent) from revolving funds.

Expense for the year totaled \$7,523,883, of which \$5,583,274 (74.21 percent) was chargeable to the continuing activities of the Association; \$405,512 (5.39 percent) to foundation grants; \$1,328,606 (17.66 percent) to federal cost reimbursement contracts; \$175,351 (2.33 percent) to council designated reserves; and \$31,140 (.41 percent) to revolving funds. Investment in fixed assets (net of depreciation) increased \$7,617 to \$435,803.

Balances in funds restricted by the grantor increased \$71,823 to \$368,856. After making provision for reserves in the amount of \$525,020, principally for equipment acquisition and replacement and MCAT and AMCAS development, unrestricted funds available for

general purposes increased \$813,021 to \$6,177,643—an amount equal to 82.11 percent of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100 percent of the Association's annual operating budget. It is of continuing importance that an adequate reserve be maintained.

The level of Association income realized from general fund sources has stabilized. General fund income during fiscal year 1977 increased 1.06 percent above fiscal year 1976. The increase during fiscal year 1978 just ended was also 1.06 percent.

The Association's financial position is strong. As we look to the future, however, and recognize the multitude of complex issues facing medical education, it is apparent that the demands on the Association's resources will continue unabated. General fund income over the last two years has been maintained at a constant level primarily by an increased return on invested funds. The budget for the current year is balanced with projected expenditures equal to anticipated income. Since a six percent inflation factor produces a requirement for an additional \$380,000 in general funds at current budget levels, it is evident that the Association must in the near future seek increased general fund revenue sources to support even the present level of program.

**Association of American Medical Colleges****Balance Sheet***June 30, 1978***ASSETS**

Cash		\$	71,805
Investments			
U.S. Treasury Bills	\$4,490,967		
Certificate of Deposit	4,050,000		8,540,967
Accounts Receivable			805,402
Deposits and Prepaid Items			26,041
Equipment (Net of Depreciation)			443,420
<b>Total Assets</b>			<b>\$9,887,635</b>

**Liabilities and Fund Balances****Liabilities**

Accounts Payable		\$	495,507
Deferred Income			1,142,105
<b>Fund Balances</b>			
Fund Restricted by Grantor for Special Purposes			368,679
General Funds			
Funds Restricted for Plant Investment	\$ 296,856		
Funds Restricted by Board for Special Purposes	963,425		
Investment in Fixed Assets	443,420		
Available for General Purposes	6,177,643		7,881,344
<b>Total Liabilities &amp; Fund Balances</b>			<b>\$9,887,635</b>

**Operating Statement***Fiscal Year Ended June 30, 1978***SOURCE OF FUNDS****Income**

Dues and Service Fees from Members		\$1,624,052
Grants Restricted by Grantor		645,283
Cost Reimbursement Contracts		1,736,663
Special Services		3,754,008
Journal of Medical Education		80,998
Other Publications		349,889
Sundry (Interest—\$531,719)		718,426
<b>Total Income</b>		<b>\$8,909,319</b>
Reserve for Special Legal Contingencies		29,547
Reserve for CAS Service Program		4,053
Reserve for Special Studies		31,956
Reserve for Data Processing Conversion		9,762
Reserve for Minority Programs		54,796
Reserve for Special Task Forces		45,237
<b>Total Source of Funds</b>		<b>\$9,084,670</b>

**USE OF FUNDS****Operating Expenses**

Salaries and Wages		\$3,722,430
Staff Benefits		518,912
Supplies and Services		2,638,914
Provision for Depreciation		82,049
Travel		561,578
<b>Total Expenses</b>		<b>\$7,523,883</b>
Increase in Investment in Fixed Assets		
(Net of Depreciation)		7,618
Transfer to Board Reserved Funds for Special Programs		405,000
Reserve for Replacement of Equipment		120,020
Increase in Restricted Fund Balances		215,128
Increase in Funds Available for General Purposes		813,021
<b>Total Use of Funds</b>		<b>\$9,084,670</b>

# AAMC Committees

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Joseph S. Gonnella  
David Jeppson  
Walter F. Leavell  
John McAnally  
Christine McGuire  
Frederick Waldman  
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Samuel O. Thier  
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Stephen Tarnoff  
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James E. Eckenhoff  
Ronald W. Estabrook

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 Judith Frank  
 Mildred Gordon  
 Judith Krupka  
 Nancy Roeske  
 Miriam Rosenthal  
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 Perry J. Culver  
 William F. Kellow  
 Robert S. Stone

*Public*

Harriet S. Inskeep  
 Arturo G. Ortega

*Federal Participant*

Robert F. Knouss

*Student Participants*

Timothy Michael Hosea  
 Peter Shields

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\* For AAMC members, see page 199.

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Kat Dolan

### Special Assistant to the President

#### for Women in Medicine

Judith Braslow

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Joseph A. Keyes

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Donna Potemken

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