Annual Report
1980–81

Note: The President's Message appeared in the January issue of the *Journal of Medical Education.*

Executive Council, 1980–81

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Thomas K. Oliver, Jr., chairman-elect
John A. D. Cooper, president

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Carmine D. Clemente
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John E. Chapman
John W. Eckstein
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William H. Luginbuhl
Allen W. Mathies, Jr.
Richard H. Moy
Leonard M. Napolitano
Edward J. Stemmler

COUNCIL OF TEACHING HOSPITALS

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Stuart J. Marylander
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John Reinertsen

ORGANIZATION OF STUDENT REPRESENTATIVES

Lisa Capaldini
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Administrative Boards of the Councils, 1980–81

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The Councils

Executive Council

Between the Annual Meetings of the Association, the Executive Council meets quarterly to deliberate policy matters relating to medical education. Issues are brought to the Council's attention by member institutions or organizations and from the constituent Councils. Policy matters considered by the Executive Council are first referred to the Administrative Boards of the constituent Councils for discussion and recommendations before final action.

Agenda items at the traditional December retreat for the Association's officers and executive staff presaged many of the issues that would appear on the Executive Council's agenda through the year: price competition in the health care sector, proposed changes in the examination sequences of the National Board of Medical Examiners and the Federation of State Medical Boards, United States citizens studying medicine abroad, the final report of the Graduate Medical Education National Advisory Committee, and changes in national policy affecting medical schools and teaching hospitals. Retreat participants engaged in a lively discussion on activities at medical centers that could be characterized as a possible "commercialization" of the academic enterprise. Since it was felt that this important topic would benefit from more widespread discussion among the Association's constituency, it was agreed that the theme of the 1981 Annual Meeting would be "Tomorrow's Medicine: Art and Science or Commerce and Industry?" A new Association project for a three year study to review the general professional education of the physician was also discussed.

The 1980 Presidential and Congressional elections set the stage for a comprehensive review of national policies and priorities. Consequently, during the past year the Executive Council has devoted considerable attention to analyzing new budget proposals for their impact on medical center activities, in reviewing existing Association positions on national policy issues for their applicability and relevance to the new political structure, and in developing and formulating responses to new proposals from the Administration and Congress.

The Executive Council endorsed a strategy emphasizing that all programs important to medical centers should be supported and funded at levels equal to the 1980 Congressional appropriations plus adjustments for inflation. The priorities set by the Executive Council were research and research training, student financial aid, programs of the Veterans Administration, institutional support including financial distress grants, and special project grants. The Executive Council also expressed its opposition to the proposed cap on Medicaid expenditures and changes in the program that would increase the flexibility of states to reduce eligibility, scope of services or freedom of choice in selecting providers. It was decided that the Association would support health planning by state and local authorities, and would not include the renewal of P.L. 93-641, the National Health Planning and Resources Development Act, as a priority of the Association. Particular efforts were required to assure the continued integrity of the National Research Service Awards program. The long-established practice under which the federal government had provided an element of institutional support for NRSA trainees came under attack. After carefully considering the options, the Executive Council adopted as Association policy the formal endorsement of the overriding importance of federal support for the training of biomedical and behavioral scientists and the principle that institutional support and indirect costs reimbursement are essential components of training awards.

In other research related action, the Executive Council decided that although federal support for independent research and development

in universities was desirable, such funding should not occur through the indirect cost mechanism. It was feared that further increases in the indirect cost pool would reduce funds available for direct research costs, cause dissension among faculty members, provide further stimulus for re-examination of rates of increase in indirect costs rates, and jeopardize the current BSRG dedicated program at NIH.

Two reports by other organizations were deemed sufficiently critical to the Association's constituents to warrant formal responses. The Executive Council was troubled by several recommendations in the final report of the Graduate Medical Education National Advisory Committee, particularly those relating to reductions in medical class size. In its response the Association said, "If the educational capacity of our medical schools is to be reduced, sufficient time must be permitted for planning and implementing the reduction. Changes in class size must take into account the diversity of the institutions, their sponsorship, their special missions, and their multiple sources of support." The Urban Institute, under contract with the Department of Health and Human Services, had examined the probable impact on undergraduate medical education of a reduction in federal subsidies, and concluded that loss of such support would not adversely impact medical education. An important corollary of this conclusion was that student loan funds must be readily available. The Association concurred with the need to ensure unlimited access to student loans, but also expressed concerns about the applicability of the report's findings for special populations of applicants and students.

Several items relating to graduate medical education appeared on the Executive Council's agenda. For five years the parent organizations of the Liaison Committee on Graduate Medical Education (now the Accreditation Council for Graduate Medical Education) had been working on revisions in the General Requirements Section of the Essentials of Accredited Residencies in Graduate Medical Education. Although there were still some concerns about the sections on evaluation and the eligibility of graduates of non-LCME accredited schools, the Executive Council joined the other four parent organizations in approving the General Essentials. The new essentials will place greater responsibility on the institutional sponsors of graduate medical education for the quality of their programs and should considerably strengthen the ability of the residency review committees and the ACGME to require that educational programs be provided adequate resources and supervision. The Council also developed a paper on due process for students and residents and one on changes in Medicare reimbursement policies on house staff moonlighting. Both papers were distributed to the AAMC constituency.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees. At the January meeting, Robert E. Tranquada, Chairman of the ad hoc Committee on Competition, presented that committee's report. The report was accepted by the Council, and served as the basis for a widely distributed Association monograph on "Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals."

The ad hoc External Examinations Review Committee, under the chairmanship of Carmine D. Clemente, was charged with studying a number of existing and proposed examinations of medical knowledge, including the National Board of Medical Examiners tests and the Federation Licensing Examination of the Federation of State Medical Boards. The Committee's report, "External Examinations for the Evaluation of Medical Education Achievement and for Licensure," was adopted unanimously at the Council's June meeting. The report concluded that the NBME's prototype Comprehensive Qualifying Examination could not evaluate the skills and personal professional qualifications that faculty of LCME-accredited schools evaluate as students progress through their curriculum. The report recommended that the Federation be urged not to require the FLEX I examination for graduates of LCME-accredited schools. The Committee further recommended that the ACGME require graduates of non-LCME accredited schools to pass both a written examination equivalent to the Part I and II exams of the NBME certification sequence and a practical hands-on examination

to evaluate clinical skills and personal professional qualifications. Licensure for independent practice, after a period of graduate medical education, for graduates of LCME-accredited schools should continue to be based on either passing the National Board certification sequence or the FLEX examination. For graduates of non-LCME accredited schools, unrestricted licensure should be based on passing the FLEX examination. The Executive Committee has met with representatives of the Federation to discuss the report; discussions continue. Prior to adoption of this report, the Executive Council at its March meeting had asked the Association representatives to the National Board to express their opposition to a proposed cooperative agreement between the Board and the Federation for the development and implementation of the FLEX I-II examination sequence.

An ad hoc Committee on Foreign-Chartered Medical Schools and U.S. Nationals Studying Medicine Abroad, under the leadership of William H. Luginbuhl, deliberated about issues raised in a report by the General Accounting Office entitled, "Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal." The committee specifically was concerned about those foreign-chartered medical schools that maintain offices in the United States to recruit U.S. citizens or to place them in U.S. hospitals for clinical experiences. The committee agreed with GAO findings that the schools to which most U.S. citizens have access do not provide a medical education comparable to that available in the United States. The committee concluded that the current eligibility standards for certification by the Educational Commission for Foreign Medical Graduates are inadequate and recommended that the ECFMG be urged to adopt the examination methods recommended by the Association's ad hoc External Examinations Review Committee The Executive Council approved and adopted the report in June. This report, "Quality of Preparation for the Practice of Medicine in Certain Foreign-Chartered Medical Schools," has been forwarded to the ACGME for incorporation into its deliberations on the standards of eligibility for graduates of non-LCME accredited medical schools.

The Executive Council has encouraged staff to seek funding for a new Association project on geriatrics and medical education. As a part of this new initiative, Robert N. Butler, Director of the National Institute on Aging, was invited to speak at a joint meeting of the Administrative Boards in September.

The September meetings of the Administrative Boards and the Executive Council also featured a special day-long session entitled, "Strategies for the Future," at which members heard presentations by Robert J. Blendon, Senior Vice President, the Robert Wood Johnson Foundation; William B. Schwartz, Professor of Medicine, Tufts University School of Medicine; David R. Challoner, Dean, Saint Louis University School of Medicine; and Julius R. Krevans, Dean, University of California, San Francisco, School of Medicine, on issues facing medical schools and teaching hospitals and their faculties and students in the 1980s. Small group sessions expanded on these discussions and began to consider appropriate Association activities for helping constituents with these problems.

The Executive Council considered and recommended to the Assembly two changes in the Association bylaws. The first would slightly modify eligibility criteria for election to Distinguished Service Membership. The second would specify the composition of the Executive Council to include the immediate past chairman and the chairman-elect of each Council. Further, the size of the Executive Council would be expanded by one to include the immediate past chairman of the Assembly.

During the year the Executive Council continued to oversee the activities of the Group on Medical Education, the Group on Student Affairs, the Group on Public Affairs, the Group on Business Affairs, and the Group on Institutional Planning.

The Executive Council, along with the Secretary-Treasurer, Executive Committee and the Audit Committee, exercised careful scrutiny over the Association's fiscal affairs, and approved a modest expansion in the general funds budget for fiscal year 1982.

The Executive Committee met prior to each Executive Council meeting and conducted business by conference call as necessary. The

Executive Committee met twice with the Association of Academic Health Centers' executive committee to facilitate coordination and communication between the organizations. The Executive Council also met with Department of Health and Human Services Secretary Richard S. Schweiker and Chairman Henry A. Waxman of the House Subcommittee on Health and the Environment to discuss issues of concern to the academic medical community.

Council of Deans

The Council of Deans held two major meetings during the 1980–81 year including the business meeting conducted at the Association's Annual Meeting in Washington, D.C. and a spring meeting in Colorado Springs, Colorado. In addition, the COD Administrative Board met quarterly to review Executive Council agenda items of significant interest to the deans and to carry on the business of the COD. More specific concerns were addressed by smaller groups of deans brought together by common interests.

Preceding the annual business meeting, Dr. Cornelius J. Pings, Director of the National Commission on Research and Vice Provost and Dean of Graduate Studies at the California Institute of Technology, addressed the Council on the relationship between academic research and the federal government. He highlighted a number of the key recommendations appearing in the Commission's reports. The primary discussions at the business meeting focused on an analysis of the various health manpower proposals and the recent efforts to amend the statutory authority of the National Institutes of Health. Progress reports were presented by the Committee on the Identification of the Unique Characteristics of the Teaching Hospital and the Committee on Competition. In addition, the Council adopted a statement opposing the action of the Board of Regents of the University of the State of New York in its decision to accredit certain foreign medical schools.

Eighty-nine deans attended the March 29–April 1 spring meeting devoted to "Academic Medicine—Crosscurrents of the Eighties." Robert M. Heyssel, Executive Vice-President and Director of The Johns Hopkins Hospital, and Emmett H. Heitler, former chairman of the Board of the Samsonite Corporation, discussed the academic medical center and the competitive environment. Arnold S. Relman, Editor of the *New England Journal of Medicine*, elaborated on his concerns about the commercialism of medicine. A perspective on the Government Accounting Office report on U.S. foreign medical students was provided by William B. Deal, Dean of the University of Florida College of Medicine. The relationship of medicine to the university was addressed by William H. Danforth, Chancellor of Washington University, and Donald Kennedy, President of Stanford University. Edward N. Brandt, Jr., Assistant Secretary for Health, Department of Health and Human Services, presented a Washington perspective on medicine in the 1980s. The presentations stimulated much discussion among the deans regarding academic medicine in the next decade.

The spring meeting was preceded by an orientation session for new deans in which they were introduced to the staff, resources and programs of the AAMC. Several COD Board members gave personal insights to the new deans "on being a dean." The business meeting included an extended discussion of the Administration's recent budget proposals and national legislation affecting biomedical research, medical education and health services.

Additional agenda items included consideration of the Federation of State Medical Board's proposed "single route to licensure", a report on the deliberation of an AAMC committee on foreign medical schools; the report from the AAMC ad hoc Committee on Competition; processes and procedures for academic and disciplinary decision-making related to students and house officers; and a progress report on the study of the unique characteristics of the teaching hospital.

Several items considered by the COD Administrative Board during its quarterly meetings deserve special note: the modification of the Health Care Financing Administration policy on resident moonlighting and the formulation of the AAMC response to the GMENAC Report. In addition, the Board approved a change in the COD Administrative Board.

Sections of the Council meeting during the year were the Southern deans, the Midwes

deans, deans of private freestanding schools, and the deans of the new and developing community based medical schools.

Council of Academic Societies

In its 13 year history, the Council of Academic Societies has not been more active or played a more important role in AAMC activities than in 1980–81. Membership in CAS now totals 71 academic societies representing over 100,000 U.S. medical school faculty members from almost every basic and clinical science discipline.

Three major meetings dominated the activities of CAS during the last year. At the 1980 fall meeting, the CAS sponsored small group discussions on four timely issues: development of faculty leaders for research careers, competitive marketing of medical services, increasing interspecialty cooperation in graduate medical education, and the changes in faculty responsibilities in accounting for research activities. In addition, Jules Hirsch, Professor and Senior Physician, Department of Human Behavior and Metabolism, Rockefeller University, addressed the Council on the status of clinical investigation and the decline of medical student interest in research. Also in conjunction with the fall meeting, a CAS "Forum on Faculty" was held; AAMC staff members presented data on the changing characteristics of faculty and of factors influencing the choice of academic careers, and Jeremiah A. Barondess, Clinical Professor of Medicine at Cornell University, discussed the role of volunteer clinical faculty.

The February CAS Interim Meeting focused almost entirely on proposed changes in the National Board of Medical Examiners sequence and the single route to licensure (FLEX I-II) advocated by the Federation of State Medical Boards. Presentations were made by officers of the Federation and the National Board regarding the proposed changes with special attention to the development by the NBME of the Comprehensive Qualifying Examination (CQE) for use as FLEX I. In small discussion groups the Council examined a 330-question sample from the CQE Prototype. The following day leaders from each group reported on their respective group's discussion and it was during the course of these reports that the Council reached a consensus opposing implementation of a single route to licensure. Members of the Association's ad hoc External Examinations Review Committee were present at the meeting and many of the concerns expressed were subsequently incorporated into that committee's final report.

In addition to the regular fall and interim meetings, the CAS held its first public affairs meeting. Public Affairs Representatives from 47 of the 71 member societies convened to discuss the Reagan Administration budget proposals. Presentations were made by Robert J. Rubin, Special Assistant to the Secretary, Department of Health and Human Services; Herbert Pardes, Director, National Institute of Mental Health; Robert Graham, Acting Administrator, Health Resources Administration; Donald S. Fredrickson, Director, National Institutes of Health; and William J. Jacoby, Chief Medical Director, Veterans Administration. AAMC President John A. D. Cooper discussed the possible impact of the budget proposals on medical schools and teaching hospitals and their faculties.

The CAS Administrative Board conducted the business that arose throughout the year during quarterly meetings held before each Executive Council meeting. Preceding its meetings, the Board had informal discussions with Stephen A. Grossman, Majority Counsel, Senate Committee on Labor and Human Resources; Sheila P. Burke, professional staff member, Senate Finance Committee; and George A. Keyworth, Director, White House Office of Science and Technology Policy.

The quarterly *CAS Brief* continued to inform medical school faculty about current policy issues. The Association also continued its CAS Services Program for societies desiring special legislative tracking and office management services. Five societies participated in the program in 1980–81: American Federation for Clinical Research, Association of Professors of Medicine, American Neurological Association, American Academy of Neurology, and Association of University Professors of Neurology.

Council of Teaching Hospitals

The Council of Teaching Hospitals held two general membership meetings during 1980–81. The theme for the COTH General Session at

the fall annual meeting was "The High Cost Patient Implications for Public Policy and Teaching Hospitals." Featured speaker Marc J. Roberts, Professor of Political Economy and Health Policy at the Harvard School of Public Health, emphasized that resource limitations and the pressures for cost containment would force society to make difficult social choices regarding the allocation of health benefits. He believed that the greatest impact would be on the high cost patient. He recommended that teaching hospital executives consider strategies to maintain the hospital's place in the health care market, develop an internal plan to make choices and implement them with consensus, centralize resource allocation, reassess health planning, develop systematic data on the cost-benefit production function of health care, and address the consequences of devoting resources to different classes of patients.

Frank Moody, Chairman of Surgery at the University of Utah College of Medicine, and Irvin Wilmot, Executive Vice President, New York University Medical Center, were respondents to Dr Roberts' remarks.

On May 6–8, 1981, COTH's fourth spring meeting was held in Atlanta, Georgia In his keynote speech on "Health Care and The American Economy in the Eighties," Ralph S. Saul, Chairman and Chief Executive Officer of INA Corporation, asserted that the principal task for both health care providers and consumers would be "to make do with less." He emphasized that funds for health care are a finite resource and improved management would be needed to get more for the dollars expended

Dennis S. O'Leary, Dean for Clinical Affairs at George Washington University Medical Center, recounted the hospital's experiences in the aftermath of the attempt to assassinate President Reagan. Dorothy P Rice, Director of the National Center for Health Statistics, presented detailed tables and charts on "Morbidity, Mortality and Population Trends in the United States," describing the dramatic increase in the percentage of the elderly in the total U.S. population The implications of the trends described by Ms. Rice were discussed by J Alexander McMahon, President of the American Hospital Association, speaking on "The Implications for Traditional and Emerging Services"; Saul J Farber, Acting Dean of the New York University School of Medicine, on "The Implications for Educational and Research Objectives"; and Loretta Ford, Dean of the School of Nursing at the University of Rochester on "The Implications for the Spectrum of Nursing Services." William C Richardson, Associate Dean at the School of Public Health at the University of Washington, spoke on "Physician Performance in Prepaid Medical Plans."

Individual workshops enabled small groups to discuss consumer choice and competition and their potential effects on teaching hospitals In another session Veterans Administration medical center directors met with representatives of the VA's Chief Medical Director.

Representative Barber B Conable, ranking minority member of the House Ways and Means Committee, spoke on "Social Security Medicare, and Medicaid: Likely Developments in the Eighties." J. Ira Harris, general partner of Salomon Brothers, spoke on "Acquiring Capital in the Eighties," warning that drastic changes in capital financing would have to be met by major changes in hospital management philosophy. Speaker Henry E. Simmons, a principal with the accounting/management consulting firm of Peat, Marwick, Mitchell and Company, in an address on "American Industry: The New Tough Buyer of Health Care," declared that "competition is the future" and "the traditional hospital setting is dead." He further predicted that, as major buyers of health care, government and big business will seek new systems of health care.

The meeting's last session presented a report on the status of the COTH study on diagnostic case mix and other distinctive features of teaching hospitals Mark S. Levitan, Executive Director of the Hospital of the University of Pennsylvania and Chairman of the AAMC ad hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals provided an overview, describing some of the problems that had been experienced with the data and their collection, and presenting preliminary statistics that had been compiled

The COTH Administrative Board met five times to conduct the Council's business and to review and discuss Executive Council agenda

items Throughout the year the Administrative Board examined the various "pro-competition" proposals that have been introduced, their potential impact on teaching hospitals, and alternatives for addressing the issues In other deliberations, the Administrative Board focused on several topics the report of the Association's ad hoc Committee on Competition, interaction with the Commission on Professional and Hospital Activities, the revised General Requirements Section of the Essentials of Accredited Residencies in Graduate Medical Education, Medicare's reimbursement policy on resident moonlighting, the Association's project to describe and quantify the case mix and service characteristics of teaching hospitals, and the potential impact on teaching hospitals of various Medicare and Medicaid proposals contained in the budget reconciliation legislation under consideration by the Congress

Preceding four of its meetings, the Administrative Board held informal discussions with various governmental officials and allied health organization executives. Howard Newman, Administrator of the Health Care Financing Administration, discussed the agency's objectives under the Carter Administration. Gail Warden, Executive Vice President of the American Hospital Association, and Howard Berman, AHA Group Vice President, spoke on the future of the Commission on Professional and Hospital Activities and other health care topics of mutual interest. Shiela P. Burke, professional staff member of the Senate Finance Committee, reviewed the budget reconciliation process and the various Medicare and Medicaid spending reduction proposals. Carolyne Davis, Administrator of HCFA, discussed that agency's activities under the Reagan Administration.

Organization of Student Representatives

During the past year five medical schools that had previously not participated in OSR chose to designate a representative, for a total of 117 schools active in the Organization Ninety-four sent students to the annual meeting during which OSR sponsored discussion sessions on curricular reform vis-a-vis the "new biology," the National Resident Matching Program, sociobiology, lessons for U.S health care from other countries, and other topics of special interest to students This year students also attended the Women in Medicine general session During its business meeting, the OSR passed 17 resolutions on issues such as improved teaching of cost effectiveness of medical procedures, the unique needs of the elderly, languages of local patients, basic clinical procedures, and the ethical responsibilities of physicians. Students also called for teaching methods that encourage development of problem-solving and life-long learning skills, for departments to provide faculty with opportunities to improve their teaching skills and to give greater weight to teaching ability in the evaluation of faculty, for improved counseling of premedical students about the diversity of approaches to preparing for a medical career, and for national examinations to be criterion rather than norm referenced-based in the determination of who passes or fails.

The Administrative Board met before each Executive Council meeting to coordinate OSR activities and to formulate recommendations on matters under consideration by the Council Of these, the OSR Board gave the greatest attention to development of AAMC's response to the GMENAC report, due process for house staff, moonlighting by residents, problems related to U S students studying medicine abroad, and the deliberations of the ad hoc External Examinations Review Committee. The Board nominated students to serve on AAMC committees and made its nominations for student participation on the LCME The Board also discussed ways in which the Consortium of Medical Student Groups can more effectively meet its information-sharing and legislation-influencing goals. One project begun by the Board was the design of a survey to obtain information from medical school deans, faculty and students on what schools are doing to foster in students an awareness of their ethical responsibilities as physicians-in-training and as practitioners, this project will include an examination of the problem of unethical behavior during training

During the winter the result of OSR's work on due process guidelines for medical students was mailed to student affairs deans, GME cor-

respondents and OSR members; this mailing included an analysis of the policies regarding student grievances currently being used by schools and a set of model guidelines for adaptation by schools should they wish to modify theirs. One issue of *OSR Report* titled "Facing the Challenges of the Physician Manpower Scenario" was mailed to all U.S. medical students; this issue offered an overview of federal support for medical education, physician manpower studies, programs designed to improve distribution, and the implications of the presently available information for medical students as they develop their career plans.

National Policy

During the past year, national policy has focused virtually exclusively on the issue of federal expenditures and revenues. Single-minded concern with domestic fiscal policy dominated the final actions of the now defunct 96th Congress as well as those of the fledgling 97th Congress. In broad strokes, the behavior of the legislative and executive branches of government in the early 1980s was characterized by growing support for retrenchments in federal spending on domestic initiatives.

Last fall the 96th Congress was understandably preoccupied with the November elections; consequently much of its work was delayed until the outcome of that contest was assured. The new Administration headed by President Ronald Reagan was deeply dedicated to a conservative philosophy regarding the scope and role of the federal government. The guiding force behind the policies of the new Administration was predicated on reductions in government spending and taxation, elimination of unnecessary or reformation of overly burdensome regulations, and encouragement of a consistent monetary policy.

Traditional processes for appropriations and continuing budget resolutions, as well as a relatively untested one called reconciliation, became the focus for Congressional, and thus the Association's, concern as devices for responding to vocal and mounting public concern about the prevalence of double-digit inflation. But ultimately, it was the new President's ability to persuade Congress to accept his economic program that produced sweeping transformations in federal spending and taxation policy.

On the appropriations front the increasingly common practice of funding health programs through a continuing resolution did not present any real difficulties until 1980 when three separate resolutions were required. The First Continuing Resolution provided FY 1981 funding only until December 15, 1980, for health research, education and service delivery programs at the lower of their present level or the House adopted level. The Second Continuing Resolution also stopped short of providing funding authority for the remainder of the fiscal year. The conferees set June 5, 1981, as the expiration date of the resolution because that was believed to be the approximate point at which federal spending would exceed the agreed upon ceiling.

Concerns about FY 1981 spending were exacerbated when President Carter submitted to the Congress his FY 1982 budget, which included substantial rescission requests for the fiscal year in progress. Moreover, the Reagan Administration lost no time in embellishing upon the previous submission, in most instances recommending much lower FY 1982 appropriations for domestic initiatives, and more severe FY 1981 rescissions for programs of paramount concern to the Association's constituents. Biomedical and behavioral research and research training, student assistance, institutional support and veterans medical programs were especially hard hit by the new rescission requests.

Rescission legislation, a bill that proposed cancellation, in whole or in part, of budget authority previously granted by Congress, together with consideration of a Third Concurrent Budget Resolution for FY 1981 and a First Concurrent Budget Resolution for FY 1982 proceeded on virtually identical schedules.

The Association, concerned with the immediate impact of the proposed rescissions, testified against these retrenchments before both Senate and House appropriations subcommittees as well as before committees concerned with veterans programs; testimony highlighted the potentially devastating impact the Administration's proposals would have on research, research training, medical education and VA health care and research. By June, the House and Senate concurred on a Third Continuing Resolution for FY 1981 that contained $14.3

billion in rescissions. The agreement embodied provisions which eliminated support for capitation, put a severe crimp in research and training programs administered by the Alcohol, Drug Abuse and Mental Health Administration, reduced by a small margin support for the NIH and for student assistance, but did not impair VA health care programs.

Against the backdrop of the FY 1981 rescissions controversy, the Congress was also considering the FY 1982 budget. The 1974 Budget and Impoundment Control Act established the procedures and a timetable for Congressional actions related to overseeing and controlling federal expenditures and revenues. The new Administration proved to be exceptionally adroit in employing the authorities embodied in this largely untested statute to achieve fiscal retrenchments.

Last year, in acting on the First Concurrent Resolution on the budget for FY 1981, the Congress broke tradition and agreed to carry out reconciliation in conjunction with the spending targets described in that legislation rather than postponing it until the binding Second Concurrent Resolution was enacted late in the budget process. Despite an initial display of enthusiasm, the Congress failed to effectively combine reconciliation with the First Concurrent Budget Resolution.

In the new Congress the House and Senate set to work with determination to fashion budget resolutions for FY 1982 and what remained of FY 1981.

The Senate majority was fully in accord with the President's final proposals and took the lead on budget issues, explicitly acknowledging that its bills "represented a dramatic change in government spending policies."

The House adopted similar targets in May in what proved to be the first in a series of budget battles in which the Administration would emerge victorious. Initially the House majority sought to counter the President's spending policies and thus, championed a bill that was more sparing of domestic programs than that enacted by the Senate. However, a solid House minority joined ranks with a small group of southern Democrats to defeat the more liberal measure and to enact in its stead the proposal championed by the Administration. This controversy marked the first appear ance of the coalition of conservative southern Democrats that would consistently support the Administration. The Congress then began to implement the reconciliation instructions contained in the newly agreed upon First Budget Resolution. The reconciliation instruction called upon virtually all committees to revamp the programs under their purview to achiev specified levels of savings. The discretionar and entitlement health programs of paramoun concern to medical centers were endangered a a consequence of the zeal of the Congress to abruptly curtail federal spending.

The work on reconciliation proceeded le smoothly in the House than in the Senate. I the House Committee on Energy and Commerce, the parent committee for most healt programs, partisan disputes deadlocked ap proval of action by both Subcommittee and ful Committee, and two versions of the require reconciliation legislation emerged. One, em bodying Chairman John Dingell's proposal was endorsed by the AAMC; the other strongl reflected OMB influence. When the Committe failed to reach accord on either version, th choice was deferred to the full House member ship. On the House floor a bitter partisan battl was waged over reconciliation legislation wit the ultimate adoption of an alternative an more austere reconciliation bill backed by th Administration. However, the final packag included the more generous health provision that the Association had endorsed.

Conferencing the House and Senate recor ciliation bills proved to be especially difficu in the area of health, but on balance, the agre ment that emerged preserved support for th programs of central interest to the AAMC constituents. The final reconciliation packa approved by the Congress went beyond strictl budgetary matters, and functioned as a vehic for reauthorizing the health manpower an research training legislation that had bee mired in a seemingly irresolvable Committe deadlock. Moreover, entitlement progra such as Guaranteed Student Loans and Med care and Medicaid were affected by the reco ciliation efforts and emerged visibly, and pe haps permanently, altered.

Health manpower proposals had been a

proved by both chambers during the 96th Congress, but House and Senate conferees were never able to reconcile their divergent views to produce a consensus bill.

In the 97th Congress manpower programs came under early attack via rescission requests. Specifically, the new Administration requested the abolition of the capitation and the Health Professions Student Loan programs, and abridgements of Family Medicine Training and General Medicine and Pediatrics programs. With the exception of capitation, the Congress ultimately approved rescissions much less severe than those advanced by the Administration.

Reauthorization of the manpower programs surfaced on the Congressional agenda early in the year. The Association testified on both sides of the Hill, stressing that federal participation in the medical education enterprise represents an appropriate and important utilization of federal resources.

The Senate Labor and Human Resources Committee reported manpower legislation in early May (S.799). The bill called for significant alterations in and dissolution of a number of manpower programs, and advanced spartan authorization ceilings for the remaining activities. The most troublesome aspect of S.799 was its very limited provisions for student assistance.

In the House, renewal of health manpower programs became entrained with, and ultimately resolved through, the reconciliation process. Although manpower legislation had been introduced and hearings convened, the responsible subcommittee had failed to formally report a bill. As Congress became embroiled in the process of slashing programs in accordance with reconciliation directives, it was decided to reauthorize the manpower program through that process, and the bill developed by Subcommittee Chairman Henry A. Waxman was incorporated into the reconciliation bill enacted by the House in late June.

Resolution of the divergent health manpower provisions of the two chambers proved difficult because the Senate approach to program reductions involved capping appropriations levels while the House measure, which prevailed, urged the conferees to reauthorize the manpower statute through the reconciliation process at the higher funding levels.

Much like the health manpower programs, the National Research Service Award program of NIH and ADAMHA came under sharp attack by the new Administration. A rescission proposal entailed eliminating institutional allowances and indirect cost reimbursement, both vital components of the programs, and reducing the number of trainees by 788 to a total of 10,000 for the NIH. The Association's testimony strongly defended the importance of the biomedical research training enterprise and emphasized the essentiality of institutional support and indirect costs to the quality of that endeavor. Both HHS Appropriations Subcommittees proved to be strong advocates of biomedical research training. The approved reductions in the research training amounted to less than 20 percent of the Administration's original proposals and the provision for institutional support and indirect costs was strongly endorsed in the reports accompanying the bills.

Unlike most of the programs operated under the auspices of the NIH, the NRSA program requires periodic reauthorization and legislative action was needed before September 30, 1981. Along with NRSAs, the committees also included considerations of Medical Library Assistance and the National Centers for Health Statistics, Health Care Technology, and Health Services Research, dubbing the measure an "omnibus health" bill.

During the Senate's hearings, the Association emphasized the importance of reversing the decline in the number of physicians entering research training and stabilizing federal support for biomedical research training. The important contributions that reimbursements for indirect cost and institutional allowances make to sustain the high quality of biomedical research training programs were also highlighted. The Association also objected to provisions in the Senate bill that compromised three medical library assistance grant programs and the National Centers. The Labor and Human Resources Committee never reported a bill, as the measure became deadlocked in Committee.

In early June the House convened a markup for its omnibus health bill. The House markup

also deadlocked. At that point a decision was reached to try to include the bill in the House's reconciliation package.

In lieu of incorporating the Senate omnibus health bill in that chamber's reconciliation legislation, Senate Committee Chairman Orrin Hatch inserted both authorization ceilings for NRSAs and an overall cap on NIH appropriations, together with an explicit assumption that an omnibus health bill would be enacted later in the year. Again, Senate and House proposals were deeply divergent. In the reconciliation conference, the issue was resolved quite rapidly with the conferees agreeing to reauthorize the National Research Service Award program for two years at amounts closer to the higher House-passed figure, and to retain the current statutory provision mandating institutional support components for the awards.

While the outcome was, in general, better than might have been expected, future amounts of research training support are sure to be somewhat less than currently provided. Report language accompanying the conference bill clearly states that the final balance between numbers of trainees and levels of institutional support is to be determined by HHS under the general guideline that the number of trainees be near that currently supported and that the level of institutional support be close to that now provided. In addition, all current authorities for medical library assistance were retained and all three of the National Centers were reauthorized for three years.

Assistance programs for post-secondary school students also fell victim to the reconciliation retrenchments despite the fact that legislation renewing and revising these programs had been enacted only a few months earlier.

Of particular concern was the reauthorization of the Guaranteed Student Loan program, the major source of assistance to medical students, in the 1980 Higher Education Act renewal. The 1980 statute raised the interest rate for loans to new borrowers under this program to nine percent from the prevailing level of seven percent. In addition it increased the total borrowing limit for undergraduate and graduate education, granted discretionary authority to increase the borrowing limit applicable to graduate and professional students pursuing programs deemed "exceptionally expensive," permitted deferral of repayment for a two-year period for borrowers serving internships required for professional practice, and decreased the prevailing 9–12 month grace period before repayment to 6 months. Finally, the law contained a particularly desirable provision permitting the consolidation of certain loans, unfortunately specifically nullified by later legislation; had it not been repealed, it would have proved extremely beneficial for medical students with the higher interest rate HEAL loans.

Reducing the cost of the GSL program emerged early as a priority of the new Administration, and Congress sought to reduce the scope of the program through the reconciliation process. The final accord reached on the GSL program was somewhat more generous than that initially advanced by either the House or the Senate. It limited eligibility to students with adjusted gross family incomes of $30,000 or less and, for higher income families, to applicants able to document need. The conferees also agreed to require all students to pay a 5 percent origination fee upon receipt of their loans. The final version retains all periods of deferral now embodied in current law, including the two-year deferral for "internships."

The final version of the reconciliation bil addressed five Medicare items of particula interest to AAMC members. Positions advocated by teaching hospitals were adopted o two issues. Conferees agreed to omit the proposal requiring that interest earned on funde depreciation be offset against interest paid o capital indebtedness, and to modify the prospective renal dialysis rate. On two other issue conferees reached an accord on provision which imposed a significant payment reductio on hospital services by requiring that the general inpatient routine service cost limits be at no more than 108 percent of the group mea (presently 112 percent), and that a new payment limitation on the costs of hospital an clinic-based out-patient visits, excluding emergency room visits, be established based o charges of physicians for comparable offic visits. Both of these payment limitations wil have particularly adverse impacts on teachin hospitals. Finally, conferees agreed to redu the present 8.5 percent Medicare nursing dif ferential to 5 percent.

In terms of the Medicaid program, despit

considerable pressure by the Administration, the conferees rejected all proposed versions of a cap, instead reaching consensus to reduce the projected federal payment for the Medicaid program by 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984.

Action on a number of other national policy issues of concern to the Association's constituents occurred outside the reconciliation process. Legislation to reorganize the National Institutes of Health and to revamp the funding mechanism for biomedical research occupied much of the time and energy of AAMC staff during the 96th Congress. Although both chambers passed bills by overwhelming margins, the conferees were unable to reach agreement on a consensus measure. Particularly troublesome were proposals embodied in both measures that would have established authorization ceilings and short-term authorities for each of the institutes. Several items initially incorporated into the biomedical research bills were enacted. The final legislation contained a series of miscellaneous provisions that reauthorized the National Cancer Institute and the National Heart, Lung and Blood Institute until the end of fiscal year 1982, renamed the National Institute of Arthritis, Metabolism and Digestive Diseases as the National Institute of Arthritis, Diabetes and Digestive and Kidney Disease, provided for training stipends from Diabetes Research and Training Centers and Multipurpose Arthritis Centers funds, established a Digestive Diseases Advisory Board, and required HHS to contract with the Institute of Medicine for a review of previous and ongoing neurological research and to outline a five-year plan for further research. Although specific biomedical research legislation has not yet emerged in the 97th Congress, Senator Hatch recently proposed to place an authorization ceiling on the NIH appropriations. The rationale for the proposal was to assure that FY 1982 spending levels for the NIH did not exceed the Administration's recommendations. Some observers view the proposal as a prelude to the resumption of consideration of legislation similar to that proposed in the last Congress.

The Congress voted overwhelmingly on August 27, 1980, to override President Carter's veto of legislation to revise and make permanent the authority of the Veterans Administration to enter into special pay agreements with physicians and other health professionals employed by the VA's Department of Medicine and Surgery. This law considerably improved the current situation by providing substantial increases in bonus pay and more favorable retirement benefits. Despite early assurances by the new Administration that the budget of the Veterans Administration would not be subject to funding reductions, the Reagan budget recommended large cuts in important VA programs including those authorized by this law. The Association registered its protest to these proposals in appearances before the relevant Appropriations Subcommittee as well as a special House Budget Subcommittee. In the final analysis, the Congress largely ignored the Administration's recommendation and provided the funds necessary to implement the physician pay bonuses and denied virtually all the rescission requests directed at VA medical care programs.

Measures requiring that 10 to 15 percent of the research and development budgets of federal R&D agencies be spent with small business firms were introduced in the 96th Congress and, in more modest (1 percent set-aside) forms, into the 97th; one, in particular, has received wide support. The proposal, advanced in identical Senate and House bills, most disturbing to the Association, mandates that one percent of the R&D budget of major research agencies be sequestered for grant and contract awards to small businesses. Essentially, the legislation would circumvent the traditional policy of awarding funds on the basis of the technical merit of the work proposed and competence of the performer.

Despite the fact that the various bills designed to promote "humane" research methods were not subject to action in the 96th Congress, similar measures have been reintroduced this year. The issues at stake involve fund set-aside for developing research and testing methods alternative to those involving live animals, mandatory adoption of alternative methods of demonstrated validity, and prohibition on the use of federal funds for "duplicative" research involving live animals.

The Department of Health and Human Services and the Food and Drug Administration

published separate sets of regulations governing the activities of Institutional Review Boards and the protection of human research subjects in January 1981. The final rules, while not completely satisfactory from the Association's perspective, represent a substantial improvement over the proposed regulations issued in August 1979. Of particular concern in these proposals were inconsistencies between the two policies, the imposition of scientific review functions on IRBs and the establishment o burdensome paperwork requirements. Gener ally, the Association was satisfied with the HH proposal, but encountered serious problem with the FDA proposition. A review of th final rules indicates that many of these prob lems were eliminated or at least mitigated, al though troubling disparities remain in the area of assurances, inspections, sanctions and con fidentiality.

Working with Other Organizations

ast year the five parent organizations of the oordinating Council on Medical Education - the American Board of Medical Specialties, he American Hospital Association, the Amer-an Medical Association, the Council of Med-al Specialty Societies, and the AAMC — greed to reorganize the CCME. In 1981 the ew Council for Medical Affairs met for the rst time. Unlike the CCME, the CFMA does ot have a coordinating role over accreditation ctivities, but it does provide an opportunity or these similar but diverse associations to iscuss issues affecting medical education. Vith each parent organization naming its top wo elected officers and its chief executive of-cer as its representatives, the CFMA has be-ome a valuable forum for the exchange of leas and opinions, and has fostered coopera-ive activity in several important areas.

Since 1942 the Liaison Committee on Med-al Education has served as the national ac-rediting agency for all programs in medical ducation leading to the M.D. degree. The .CME is sponsored by the Council on Medical ducation of the American Medical Associa-ion and the Association of American Medical olleges. Prior to 1942, and beginning in the te nineteenth century, medical schools were eviewed and approved separately by the AMC and the AMA. The LCME is recog-ized by the physician licensure boards of the 0 states and U.S. territories, the Canadian rovinces, the Council on Postsecondary Ac-reditation and the Department of Education.

The accrediting process assists schools of edicine to attain prevailing standards of ed-cation and provides assurance to society and e medical profession that graduates of ac-edited schools meet reasonable and appro-riate national standards; to students that they ill receive a useful and valid educational ex-erience; and to institutions that their efforts nd expenditures are suitably allocated. Survey ams provide a periodic external review, iden-tify areas requiring increased attention, and indicate areas of strength as well as weakness. The findings of the LCME have been used to establish national minimal standards by universities, various government agencies, professional societies, and other organizations having working relationships with physicians.

The LCME, through the efforts of its professional staff members, provides factual information, advice, and both informal and formal consultation visits to newly developing schools at all stages from initial planning to actual operation. Since 1960 forty-one new medical schools in the United States and four in Canada have been accredited by the LCME.

In 1981 there are 126 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences and four have not yet graduated their first classes and consequently are provisionally accredited. The 122 schools that have graduated students are fully accredited. Additional medical schools are in various stages of planning and organization. The list of accredited schools is found in the *AAMC Directory of American Medical Education.*

A number of new medical schools have been established, or proposed for development, in Mexico and various developing island countries in the Caribbean area. These entrepreneurial 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.

On January 1, 1981, the Liaison Committee on Graduate Medical Education was transformed into the Accreditation Council for Graduate Medical Education. This change,

which grew out of discussions held by the five sponsors in the newly formed Council for Medical Affairs, was accompanied by an increase in membership from two to four each for both the American Hospital Association and the Council of Medical Specialty Societies. The ACGME now has 20 members appointed by the sponsors, a public member, a resident member, and a non-voting federal representative.

The financing of accreditation activities for graduate medical education was also changed. A $25.00 a year charge for each resident was levied in addition to charges for accreditation surveys. During 1981 the AMA continued to support the ACGME by underwriting any deficits during the transition toward financial independence. Beginning December 1, 1981, the ACGME is expected to generate sufficient income to support all accreditation activities. The activities of the ACGME that relate to policy development will be financed by the five sponsoring organizations.

The bylaws of the ACGME require that staff services for the ACGME be provided by one of the five sponsors under the terms of a written memorandum of understanding. A subcommittee of the ACGME has met with AMA representatives to negotiate a memorandum with that organization. It is anticipated that a memorandum of understanding, to become effective December 1, 1981, will be approved by ACGME and its sponsors.

The ACGME has been empowered to authorize residency review committees to accredit graduate medical education programs under terms and conditions specified by the ACGME. Several RRCs have indicated a desire for such authority. Policies and procedures to delegate accreditation authority to requesting RRCs have been developed.

Other notable actions by ACGME this year were the ratification of the revised General Requirements Section of the Essentials of Accredited Residencies by all sponsors, the establishment of a process to implement accreditation of sub-specialty graduate medical education programs, and the initiation of procedures to accredit one year transitional programs.

At its May meeting the ACGME, after hearing a preliminary report of the AAMC's External Examinations Review Committee, requested a study committee review of the examination methods and eligibility standard currently employed by the Educational Com mission for Foreign Medical Graduates for cer tifying graduates of non-LCME accredite medical schools for entry to accredited gradu ate medical education programs in this countr

In January 1981 the newly constituted Ac creditation Council for Continuing Medic Education succeeded the Liaison Committe on Continuing Medical Education with the ful participation of all original LCCME membe organizations. This welcome reunification o the accreditation mechanism was carried ou without difficulties. The new Council immedi ately undertook the task of completing a set c Essentials which had been under preparatio by the previous organizations. After review an feedback by member organizations th ACCME approved the new Essentials in Jun and sent them to member organizations fo approval.

Once these Essentials are approved, th Council will develop a companion handboo as a guide for the continuing education pro vider seeking accreditation and for the su veyors reviewing provider organizations an institutions. The handbook will take account c the multiple settings of CME represented b the various provider organizations and institu tions.

Presently the ACCME is using a reverse sit visit procedure for the re-accreditation revie with the intent of assessing critically this revie mechanism after one or two years of operatio

The Educational Commission for Foreig Medical Graduates continues to offer its e amination for certification requirements graduates of foreign medical schools, eith U.S. citizens studying abroad or aliens wi permanent residency in the U.S. All ali FMGs who require an entry visa must sit fo the Visa Qualifying Examination developed b the NMBE and administered by the ECFMG Despite a considerable decline in alien FMG the number of candidates for the ECFM examination decreased in 1978 only tempora ily to increase again due to the larger numb of U.S. citizens studying medicine abroad an seeking admission to U.S. graduate medic education programs or to Fifth Pathway pr grams. An ECFMG Invitational Conference i October discussed issues of equivalency of e

cation and examination. The ECFMG is also ponsoring a grant program supporting re-arch and development in optimizing an MG's educational experience in the U.S. raduate programs. A new scholarship program as also been approved for support of basic ientists who wish to gain teaching experience U.S. medical educational institutions.

The Association worked closely with the RMP in its revision of the Resident Matching rogram for 1982. The revised match will per-it students to be matched into programs that gin in the first graduate year and in later ears. When fully adopted by teaching hospi-ls and program directors, the provisions of e new match should reduce pressures on stu-ents to make premature decisions to enter aduate medical education programs in cer-in specialties.

At the Association's request, the NRMP nted and distributed the Universal Applica-on Form for Graduate Medical Education hich had been developed after two years of udy. The form was distributed to medical udents at their schools for their use for apply-g to graduate medical education programs. he experience with the form in its first year of e will be studied to determine whether the stribution to students through their schools is n effective way to gain its acceptance by teach-g hospitals and program directors.

This year the proposal by the Federation of ate Medical Boards to establish a single route licensure by requiring the passing of a two rt Federation Licensing Examination se-uence came under close scrutiny, and the ssociation's Executive Committee has met th Federation representatives to discuss their ncerns.

The Coalition for Health Funding, which e Association joined with others in establish-g 11 years ago, has expanded its activities and fluence by monitoring and commenting on e development of the Congressional budget solutions in addition to the traditional efforts the appropriation process. The unpredict-lities in the evolution of the Congressional reconciliation process presented new challenges to the Coalition and emphasized the importance of cooperation with other organizations with similar interests. Efforts continue to refine the process by which the Coalition recommendations are developed and disseminated. Widespread acknowledgement of the usefulness of the Coalition's annual position on appropriations for the discretionary health programs offers significant evidence of the increasing respect in which the Coalition is held.

The diversity of the Association's interests and the nature of its constituency offers an unusual opportunity for liaison with numerous other organizations representing health care providers, higher education and those interested in biomedical and behavioral research. The Association is regularly represented in the deliberations of the Joint Health Policy Committee of the Association of American Universities/American Council on Education/National Association of State Universities and Land-Grant Colleges and in the Intersociety Council for Biology and Medicine. These liaison activities provide forums in which information on matters of national interest can be shared, varying points of view can be reconciled and collective actions undertaken in the area of federal legislation and regulation.

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 other health professions. This year FASHP has been especially concerned about health manpower legislation and budget and appropriations allocations for health manpower programs.

The Executive Committee of the Association met twice with their counterparts at the Association of Academic Health Centers. Among the agenda items at these meetings were the AAMC's new study on the General Professional Education of the Physician and the AAHC project to examine the impact of the federal budget on academic health centers.

Education

Various pressures during the last five to 10 years have focused attention on the need to assess the direction and effectiveness of our education systems. In elementary and secondary education concern about the impact of "innovative" educational philosophy and practice prompted a call for a "return to the basics." In no small way a continuing decline in the standardized test scores of graduating high school seniors was responsible for raising the alarm. The dwindling supply of public monies available during recent years to support education has placed increased emphasis on selectivity in the allocation of educational resources. This is clearly evident, for example, from reviewing recent tax support for medical education which has imposed more conditions relating to social goals to qualify for such support. Certain groups found education to lack appropriate moral fiber and have pressed for the reintroduction of spiritual values into the educational environment. In short, a variety of forces have combined to suggest a rather comprehensive reassessment of our educational mission and strategies at all levels.

In line with this trend, and having just completed an in-depth study of graduate medical education resulting in the report, *Graduate Medical Education: Proposals for the Eighties*, the AAMC has embarked on a major new venture involving a comprehensive examination of the post-secondary educational experiences preceding graduate study. Supported by a major grant from the Kaiser Family Foundation, the Association has initiated a three-year project to review and appraise the general professional education of the physician and college preparation for medicine to determine how education to the level of the M.D. degree can more effectively prepare students for their specialized education during graduate medical education and for lifelong professional learning. Under the direction of a special panel the project will involve institutional faculties and academic societies at medical schools and ur dergraduate colleges. The project is timely b cause it is now acknowledged that baccalat reate education and undergraduate medical ec ucation comprise the general preparation for medical career. At a time when education resources are limited, it is appropriate that fa ulties appraise their programs and determir how they can better accomplish their educ tional mission.

The Group on Medical Education has con centrated major attention on both of these are in the development of its programs. Continuir a cooperative effort started in 1980, the GI coordinated an annual meeting program (house staff evaluation with the Association ; Program Directors of Internal Medicine ar the Society of Teachers of Family Medicin This session combined the perspectives of tho two specialties with that of surgery and al included an overview based on informatic collected for the AAMC Clinical Evaluatic Project. The possibilities suggested by this cor bined interest for a more enduring form assistance to graduate faculty are under acti consideration.

The GME has also set in motion a phas effort to identify and analyze the issues it thin merit consideration in the study of the Gener Professional Education of the Physician.

Another subject receiving particular atte tion at each GME Regional Meeting was t status of the Comprehensive Qualifying E amination under development by the Nation Board of Medical Examiners and its relatio ship to the proposal by the Federation of Sta Medical Boards for a FLEX I/FLEX II lice sure process. The level of concern and intere generated in these meetings led to a 1981 a nual meeting plenary session with the Gro on Student Affairs. This session entitled, "T External Examination Dilemma: Impact (Student Behavior and Educational Program was viewed as an important step in encourag

formed faculty consideration of these issues nd of the report of the AAMC ad hoc Com- ittee on External Examinations Review.

The Clinical Evaluation Project continued provide valuable data. In addition to its nportance for the GME/APDIM/STFM ses- ion, it served as the basis for presentations to he January 1981 AAMC Residents Conference nd the CAS Interim Meeting. The report series rom the program is also now available. Infor- ation received from clinical faculty from ap- roximately 500 departments is analyzed in erms of issues and problems surrounding eval- ation of clerks and residents. Specialty-spe- ific data are available for internal medicine, ediatrics, surgery, psychiatry, obstetrics-gyne- ology, and family medicine. The report series ill serve as stimulus documents for three orkshops which will provide a forum for fac- lty to address evaluation issues with regard to articular departmental needs. The Resident onference itself was a useful forum for elicit- ng the views of senior residents on current valuation practices in graduate medical edu- ation and for sharing these perceptions with ey representatives of organizations with grad- ate education responsibilities.

The MCAT Interpretive Studies Research rogram now provides a wide range of data to ssist member schools in their use of MCAT ore information. Cooperative validity studies ith 27 schools are in progress; each is con- erned with the relationship between the scores sed in admissions and performance in medical hool. Summaries of findings with regard to asic science performance are expected in the oming year. AAMC staff also disseminate re- arch results on the national group of MCAT xaminees through the MCAT interpretive udies series.

To assure that after five years the New CAT science content is still current and nec- ssary as a prerequisite to the study and practice f medicine, the AAMC is undertaking a lim- ted review of the test's science content. The view for relevance as a prerequisite will be ccomplished by 150 selected medical school aculty, while the currency of the science ma- rial will be assessed by undergraduate college cience faculty.

While these necessary and productive activities are being implemented to support the admissions testing program, it continued to be necessary to dedicate significant attention to the problem posed by the threat of federal and state legislation to regulate standardized testing. At joint hearings of the House Subcommittees on Elementary, Secondary, and Vocational Education and Post-Secondary Education little new support for the legislation was in evidence, but professional organizations of testing specialists found an opportunity for the first time to voice their opposition in such a forum. Interest at the state level declined somewhat as reflected by the number of legislatures scheduling actions. Their review during the first half of 1981 failed to produce any new legislation. Meanwhile, the AAMC continues to offer the MCAT in New York under the protection of a preliminary injunction issued by a Federal District Court in New York while the constitutionality of the New York law is being reviewed.

The Continuing Education Systems Project initiated jointly with and supported by the Veterans Administration has completed the formulation of criteria for continuing education in the health professions incorporating the concepts of the adult professional as an independent learner into a set of institutional responsibilities for program planning and implementation. In close collaboration with the Regional Medical Education Centers and selected Learning Resource Centers of the Veterans Administration, the project is now developing a management and reporting system for continuing education and learning packages aimed at facilitating the application of these principles to the day-to-day operation of continuing education units in health profession schools and organizations. To test the validity of these concepts and of the criteria, the project has established close working relationships with a number of institutions and organizations including the Center for Educational Development at the University of Illinois, the Office of Research and Development for Education in the Health Professions at the University of North Carolina, the Office of Continuing Medical Education at Temple University and its affiliated hospitals, the American College of Physicians, the American Hospital Association, the Ac-

creditation Council for Continuing Medical Education, the California Medical Association, and the Committee on Continuing Education of the American Dental Association. While the project is limited to the quality of continuing education per se, ultimately the goal is to assess the impact of educational intervention on the quality of health care rendered

Another aspect of the continuing interest of the Association in assisting the promotion of quality in the educational process has been the involvement in the development of AVLINE (audiovisuals-online) as a mechanism for increased sharing of quality educational materials. Considerable effort has been expended towards developing criteria for acceptable quality of audiovisual educational materials, criteria which could guide the production as well as the critical assessment of such materials. With the assistance of the National Library of Medicine, the Educational Materials Project of the Association is promoting the concept of enhanced responsibility of the producer for quality of their productions and for the information needed to increase their potential usefulness in the instructional process

Biomedical and Behavioral Research

Significant changes in the political and economic climate affecting biomedical and behavioral research, occurring simultaneously with increased evidence of the great potential or practical applications of new research findings, epitomized a paradox of unusual promise but profound uncertainty The outgoing President proposed substantial rescissions in the appropriations for fiscal year 1981 for the National Institutes of Health and the research activities in the Alcohol, Drug Abuse and Mental Health Administration, along with budgetary proposals for fiscal year 1982 substantially below those required to maintain program levels Subsequent events involved an almost bewildering array of funding proposals and counter-proposals as well as major modifications in the legislative process as the new Administration inexorably pressured Congress for adoption of its economic strategy. "Reconciliation" assumed sudden importance as a new term in the lexicon of scientists, and the outcome of Congressional battles concerning energy and transportation became highly important because of the peculiarities of legislative packaging In part, because of strenuous efforts on its behalf but also because of fortuitous events, biomedical research fared comparatively well, both as far as proposed rescissions for FY 1981 and appropriations for FY 1982. Additionally, the National Research Service Award authority in which research training programs are dependent was renewed with several favorable features, especially as compared with initial proposals. Especially rewarding was the defeat of efforts to eliminate any possibility of institutional support as a part of training stipends. At the same time, the possibility of a worsening of the nation's economy and more drastic budgetary cuts in future fiscal years tempered a feeling of relief at the outcome of the legislative battles

Despite the intense preoccupation of the Congress with economic issues, there were legislative proposals in other areas which could have significant impacts on biomedical and behavioral research Particularly threatening were bills to establish dollar set-asides from the budgets of research-supporting agencies in order to exploit the putative capabilities of the country's small business to increase and improve "innovation" Along with other organizations, the Association vigorously criticized these proposals because the award of funds for research to small business firms would be outside the general competition with all other applicants based on scientific merit. Similarly threatening were proposals that would have required sequestration of substantial funds by NIH and other federal agencies to develop alternative methods to the use of animals in research

More gratifying was the enactment of legislation that brought long-desired consistency to federal patent policy, including recognition of institutional patent agreements as a useful incentive for moving new discoveries into widespread application There also were significant improvements in several pertinent regulations, prompted in part by the new anti-regulatory climate which developed after the last national election Thus efforts to improve the regulations covering the disposal of radioactive wastes were largely successful Changes by the National Institutes of Health in regulations governing research using recombinant DNA techniques represented similar advances, and the regulations governing the protection of human subjects in research were favorably modified after extensive negotiations in which the AAMC was involved Unresolved, however, were the issues involving how the Occupational Safety and Health Administration would propose to regulate the use of toxic chemicals Similarly persistent is the problem of time and effort reporting, an example of the difficulty in developing reasonable methods to demonstrate accountability for the use of federal funds The

subject of compensation for injured research subjects remains under consideration by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, with a pilot study being considered to explore the feasibility of a compensatory mechanism.

Increased competition for available research funds led to further discussions within the federal government, especially at NIH, and within organizations such as the Association on the increasingly nettlesome problem of the allocation of funds between direct and indirect costs. Although no specific restrictions occurred, it was apparent that research-oriented faculties and both the Administration and the Congress were increasingly determined that the ratio of funds allocated to the two types of costs should be examined, if not controlled. Institution officials, meanwhile, sought new ways to convince the critics of the essentiality of those expenditures and the needs for adequate reimbursement as justified in the support of any research program.

Prompted by the potential apparent for both medicine and other fields, particularly agriculture, in the enhanced ability to manipulate genetic material, new commercial ventures were started by faculty members to exploit th scientific and commercial possibilities. Numer ous institutions and other organizations bega to explore the complex issues in order that th public would gain by proper and prompt ap plications of these techniques, individual fac ulty members would receive their just scientifi and financial rewards, and the fiscal and sub stantive integrity of academic institutions coul be preserved.

Growing concerns abounded about the abi ity of the NIH, ADAMHA, and the Veteran Administration to recruit and retain senior sc entific and managerial leadership as the attrac tiveness of federal employment for such ind viduals decreased. For example, there wer more vacancies at senior level positions at th NIH than ever before in its history. In lar part, the continuation of unreasonable ceilin on federal salaries was responsible. Given th current mood of the Congress, it seems unlikel that this situation will improve in the immed ate future. At the same time, it was apparer that the general nature of federal employmer had become significantly less attractive at su levels. The sudden resignation of Donald Fredrickson as Director of NIH dramatize this problem.

Health Care

nterest in the development of health maintenance organizations at academic medical centers prompted the Association to cosponsor a national conference with the Kaiser Family Foundation in October 1980. The conference proceedings, available from the Kaiser Family Foundation, will include summaries of discussions on issues such as the cost of conducting educational programs in prepaid practices, the compatibility between the service objectives of prepaid practices and the educational and research objectives of academic medical centers, and the effect of prepaid practice on faculty plans. These summaries, the papers presented by the major speakers, and the case histories of academic medical center/prepaid practice affiliations provide many insights into successfully developing relationships between academic medical centers and prepaid practices.

Two books prepared by the Association under a grant from the Health Care Financing Administration focused on the teaching of quality assurance and cost containment. The major text, a resource book for faculty and curriculum planners, explores ways in which the teaching of quality assurance and cost containment can be incorporated into the medical school curriculum and residency programs and then evaluated. The history and future trends in this area also are addressed. The companion volume, intended for use by medical students and residents, provides an overview of the rationale, principles and methodology involved in learning about quality assurance and cost containment. It offers a detailed case study that illustrates a five-stage approach to the conduct of a quality assurance study and provides a series of exercises to test the reader's ability to comprehend and apply the learning material. The books are currently in publication.

In October 1980 the Association began a project on aging and long term care. Under a cooperative agreement with the Administration on Aging, the AAMC provides technical assistance to institutions with AoA grants to plan or operate multidisciplinary long term care gerontology centers. It is intended that these centers become a national resource for needed services, research, and education and training in long term care.

The Association's primary role is as a facilitator to the long term care centers and projects in obtaining their goals. The Association, therefore, promotes an exchange of information on programs and organization at each of the centers and projects, and provides the services of experts in organizational development and long term care issues to the new and advanced planning centers. In addition, the Association is developing a management information system that will collect, analyze, and report data on the accomplishments of the operational centers.

To ensure that the project activities incorporate the views and concerns of the many different disciplines involved in long-term care centers and projects, the Association established a multidisciplinary project advisory committee. The committee met in January 1981 to review AAMC's planned activities and to express their views on the major long term care issues to be addressed in the 1980s. Its October 1981 meeting will review progress to date, advise the AAMC of future directions, and discuss ways in which interest in long term care can continue to be fostered in the nation's academic medical centers.

The AAMC has also conducted workshops on organizational and program planning issues and specific substantive areas such as research on the impact of the environment on the frail elderly, training of professionals who supply long term care in different settings and at different levels of intensity, long term care policy analysis and assessment, and approaches to developing innovative models of service. A third workshop is scheduled for May 1982. The exchange of information on long term care is further enhanced by the publication of a newsletter on the LTCGC program.

Faculty

In response to an Executive Council concern and on the recommendation of the *ad hoc* Committee on Clinical Research Manpower, the Association conducted several studies pertaining to the supply, training and career-long research productivity of clinical investigators. The studies were performed under contract from the Commission on Human Resources of the National Academy of Sciences and are being published by the National Institutes of Health. One study surveyed the amount of time physician faculty spend in research and research-related activities and found characteristically different career profiles of research involvement and publication among academic physicians in different specialties. Medical and behavioral specialists publish at rates that are sustained as their careers advance, while publications profiles of surgical and hospital-based specialists peak and then decline after about age 45. Published output from physicians in basic science departments peaks early and rises again later in their careers. By combining these profiles, assumptions regarding training and growth of faculty, and age-specific rates of faculty hiring and loss, total publication output can be projected.

Another study performed for the National Academy of Sciences compared the careers of physicians who received research training through four alternative programs: NIH postdoctoral fellowship training, the NIGMS medical scientist training program (MSTP), and the NIH research and clinical associates programs. All four programs were highly successful in producing physician scientists, but the MSTP was the most successful. MSTP graduates are more likely to continue their research involvement, publish more, and rise faster through the faculty ranks than the other three matched groups of physicians.

A third study examined whether there has been a change in successive graduating classes of MDs in the fraction who join medical school faculties. Using the Faculty Roster System to examine the classes of 1967 through 1974, was found that, aside from variability in th early years after graduation, about 15 percer of each class had joined faculties within nin years of graduation. An anticipated declinin trend was not observed. It was also noted tha female graduates join faculties sooner and i greater proportions than do their male counter parts.

The rising numbers of faculty position v cancies in clinical departments, a cause of som recent alarm, was found to be proportionall matched by growing vacancies in basic scienc departments. Further studies, now in progres examine whether PhDs are increasingly hire to fulfill research roles in clinical department

The Faculty Roster System, initiated in 196 continues to be a valuable data base, containin information on current appointment, emplo ment history, credentials and training as w as demographic data for all salaried faculty U.S. medical schools. In addition to supportin AAMC studies of faculty manpower, the sy tem provides medical schools with faculty in formation for use in the completion of que tionnaires for other organizations, for the iden tification of alumni now serving on faculty other schools, and for production of speci reports.

The Faculty Roster supports a variety manpower studies, including an annual d scriptive study, funded in part by the Nation Institutes of Health. In 1980, *Trends in Medic School Faculty Characteristics, New Faculty a Continuing Faculty—1968–78,* was publishe This report differs from previous faculty d scriptive studies in its comparison of characte istics of newly hired faculty to existing facul characteristics.

As of June 1981 the Faculty Roster co tained information for 57,929 faculty; an add tional 34,732 records are maintained for "i active" faculty, individuals who have prev ously held a faculty appointment.

The Association maintains an index

omen and minority faculty, based on the aculty Roster, to assist medical schools and deral agencies in their affirmative action re- iiting efforts. The Faculty Roster staff has esponded to 180 recruitment requests from edical schools by providing the records of lected faculty meeting the requirements set y the search committees. The faculty records tilized in this service are only those for which onsent has been received from the individual aculty members.

The Association's 1980–81 *Report on Medical School Faculty Salaries* was released in February 1981, presenting compensation data for 118 U.S. medical schools and 31,712 filled full-time faculty positions. The tables present compensation averages, number reporting and percentile statistics by rank and by department for basic and clinical sciences departments. Many of the tables also allow comparisons according to type of school ownership, degree held, and geographic region.

Students

As of August 1981, 36,497 applicants had filed 337,075 applications for the entering class of 1982 in the 126 U.S. medical schools. These totals, although not final, already surpassed the final figures for the entering class of 1981.

First-year enrollment increased from 16,930 in 1979–80 to 17,186 in 1980–81 while total enrollment rose from 63,800 to 65,189. This increase represents the smallest growth in enrollment in the past five years; however, the actual number enrolled establishes a new record. A portion of the increase is attributable to a rise in the number of all minorities enrolled since 1979–80. However, the number of underrepresented minority students enrolled remains virtually unchanged since last year.

First-year enrollment of women medical students reached 4,966, a 5.4 percent increase since 1979–80, while the total number of women enrolled was 17,248, a 6.9 percent increase. In 1980–81 women constituted 28.9 percent of the first-year class and 26.5 percent of all medical students.

The application process was facilitated by the Early Decision Program and by the American Medical College Application Service. For the 1981–82 first-year class 958 applicants were accepted by the 62 participating medical schools. Since each of these applicants filed only one application rather than the average of 9.2 applications, the processing of approximately 7,850 multiple applications was avoided. In addition, the program allowed the successful early decision applicants to finish their baccalaureate programs free from concern about admission to medical school.

Ninety-seven medical schools used AMCAS to process first-year application materials for their 1981–82 entering class. In addition to collecting and coordinating admission data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admission, matriculation and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Stu dent Affairs Steering Committee.

The Advisor Information Service circulat rosters and summaries to AMCAS applican who have authorized the release of persona information to their health professions adv sors. In 1980–81, 209 health professions adv sors subscribed to this service.

During each application cycle, the AAM investigates the application materials of a smal percentage of prospective medical students wit suspected irregularities in the admission pro cess. These investigations, directed by th AAMC "Policies and Procedures for the Trea ment of Irregularities in the Admission Pro cess," help to maintain high ethical standard in the medical school admission process.

The number of Medical College Admissio Test examinees for 1980 and the projected tot for 1981 appear to indicate a general slowin of the rate of decrease in the number of MCA examinees evidenced over the past five year With the exception of the artificial increase the number of examinees in 1977 because o the introduction of the New MCAT, decreas in the number of MCAT examinees betwee 1975 and 1979 were of the magnitude of 250 3000 examinees per year. This is contrast with a 3 percent increase in 1980 over 1979 an a projected return to 1979 levels for the tw administrations in 1981. While the total num ber of examinees appears to be stabilizing, th percentage of women examinees continues increase. In 1980, 34 percent of all examine were women, compared to 27 percent in 197 Although the changes in the racial ethnic com position of the 1980 examinee group were ve small, there was a decrease in the number white examinees while the various underrepr sented minorities maintained essentially th same percentages of the examinee pool as 1979.

The Medical Sciences Knowledge Profile e amination was administered for the seco time in June 1981 and 1,776 citizens or p

manent resident aliens from the U.S. and Canada sat for the examination. The examination is provided to assist constituent schools of the AAMC in their deliberations about individuals seeking advanced placement. The MSKP program is sponsored by the AAMC and the test is developed and administered by the National Board of Medical Examiners.

While 5.7 percent of those registering for the test have degrees in other health professions, 87 percent of all registrants indicated they were currently enrolled in a foreign medical school. The total number of examinees for the 1981 administration was only 20 fewer than the number who sat for the first MSKP examination in 1980.

A two-year grant from the Department of Health and Human Services for the AAMC's Simulated Minority Admissions Exercise Workshops was successfully completed in December 1980. The grant supported sixteen SIMAE Workshops held at various medical schools across the country and involved over 300 medical school personnel including deans, department chairpersons, admissions officers, faculty and others in student affairs. The SIMAE Workshops developed by the AAMC in 1974 assist admission committees to evaluate noncognitive information on nontraditional (minority) applicants to medical school. Most recently, the Office of Health Resources Opportunity has officially notified the AAMC of the award of a new grant to support a series of workshops to be held at several medical schools in each region. These will include retention and learning skills workshops, training and development workshops for student financial aid program administrations, and a counseling workshop for minority and financially disadvantaged students accepted to medical school and for premedical advisors. Simulated Minority Admissions Workshops will also be offered in medical schools.

Efforts continued to improve the availability and types of financial assistance for medical students and the administrative expertise of medical school financial aid officers. Attempts by both the 96th and 97th Congresses to pass legislation in the areas of health manpower and education that would impact on the entire spectrum of financial aid programs available to medical students were carefully monitored. Testimony and written comments were delivered at each appropriate opportunity. Three workshops to improve the administration of financial aid at schools of medicine, osteopathy and dentistry were held during 1980–81. The grant from the Robert Wood Johnson Foundation supporting this activity will provide three more such programs.

The annual medical student graduation questionnaire was administered to the class of 1981 in 119 of the 121 medical schools with seniors. Approximately 11,000 students participated in the survey, a response rate of 69 percent. A summary report comparing national responses with individual institutional data was mailed to each medical school during the summer. Selected results appear in the 1981 Directory of the National Residency Matching Program. A comprehensive study of 1981 graduates is underway.

After two years of careful study, review, and refinement, the Graduate Medical Education Application for Residency, developed by the AAMC at the recommendation of the Task Force on Graduate Medical Education and provided by the National Resident Matching Program, was implemented this spring. Applications were disseminated, along with NRMP materials, to medical school student affairs offices for use by students planning to enter residency programs. This universal application will facilitate the process of applying for a residency position by providing a standard form for transmittal of basic information from students to hospital program directors. Program directors may request supplemental information from applicants.

In 1980–81 at the suggestion of the Group on Student Affairs "Recommendations of the AAMC Concerning Medical School Acceptance Procedures" were modified to include the provision that all schools offer sufficient places to fill their first-year class by May 15 of each admission cycle. This strategy should lessen the tension in both schools and students produced by the acceptance of large numbers of students during the summer months.

The Group on Student Affairs-Minority Affairs Section has initiated activities outlined in the implementation plan for the recommendations of the AAMC Task Force on Minority

Student Opportunities in Medicine. The first activity, a medical career awareness workshop for high school and college minority students, was conducted April 1981, in Dayton, Ohio.

A grant-in-aid was received from the Commonwealth Fund to produce a book with the working title, "U.S. Medical Students, 1950-2000: Trends and Projections." To help develop meaningful predictions regarding the characteristics of future medical students, a four-round Delphi Survey was initiated. Among the 330 participants in the survey are medical school administrators, faculty and students, preprofessional advisors, Flexner awardees and other opinion leaders. The book is scheduled for publication in 1983.

Institutional Development

In 1972 the Association initiated a program to strengthen the management of medical schools and academic medical centers. The Management Advancement Program continues to develop and conduct educational seminars, to analyze management issues, and to assist in the identification of appropriate consultant services. To date, fifty seminars have been offered; participants from 125 U.S. and 13 Canadian medical schools and 146 hospitals have participated.

The program was designed to assist institutions in the development of goals that would effectively integrate organizational and individual objectives, to strengthen the decision-making and the problem-solving capabilities of academic medical center administrators, to aid in the development of strategies and mechanisms that would allow medical schools and centers the flexibility to adapt more effectively to changing environments, and to develop a better understanding of the function and structure of the academic medical center.

The chief activity of the program this year has been the conduct of Executive Development Seminars for senior academic medical center administrators, an intensive week-long seminar on management theory and technique. During the 1980–81 year there were Executive Development Seminars for medical school deans, teaching hospital directors, chairmen of medicine, service chiefs of affiliated hospitals, and chairmen of pathology. A special seminar was offered for teams of business officers and institutional planners from twenty institutions. The third seminar for women in senior administrative roles in academic medicine was also held. In conjunction with the Veterans Administration central office, a program focused on the academic medical center-VA hospital affiliation relationship was conducted for VA hospital deputy directors as part of their professional development program in the fall of 1981. Plans are underway for additional programs for chairmen of obstetrics/gynecology, pediatrics, and general surgery. A second seminar for business officers and institutional planners will be offered in the spring of 1982.

The Management Advancement Program was planned by an AAMC Steering Committee which continues to participate in program design and monitoring. Faculty from the Sloan School of Management, Massachusetts Institute of Technology, have played an important role in the selection and presentation of seminar content. Consulting expertise has been provided by many individuals including faculty from 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 came primarily from the Robert Wood Johnson Foundation. The program is now self-supporting through the use of conference fees.

In 1976 the Management Education Network was designed to identify, document and transmit management information relevant to medical center settings. Supported from the National Library of Medicine, products from the MEN project include a study guide and companion audiovisual tapes on strategic planning, a study on medical school departmental review, and a simulation model and companion study on tenure and promotion in academic medical centers. The final report of the study of academic tenure was distributed this past year. During the course of the tenure study the information developed has been made available to many medical schools concerned with tenure questions.

The studies of the career patterns of medical school deans and vice presidents for health sciences and their implications for medical

school leadership and management are continuing, supported by the Commonwealth Fund, and will be published shortly.

The exponential growth of medical knowledge and revolutionary changes in information handling technology present important challenges to academic medicine. In response, the AAMC has undertaken studies on the future of health sciences libraries and on information handling in medical schools and hospitals. The primary focus of the health sciences library study is the library's mission and roles in education, research and patient care. Using diverse data collection instruments and with the support of an enthusiastic advisory committee, this study has as its objective the identification of policy issues and planning principles for institutional decision makers. The study aspires to provide workable models for library and learning resources management to assist in determining priorities for action and assessing needs for staff skills development. The study of the health sciences library is supported by the National Library of Medicine for two years, targeted for completion in 1982.

The study of information handling technology for hospital and medical school function is supported by The Josiah Macy, Jr. Foundation. This eighteen month study will assist in strategic planning for information management in the academic medical center. Tasks of the study are to collect, analyze, and disseminate information about available and new technology and to provide a basis for assessing the impact of technology on the information handling functions of the academic medical center. Current information handling practices will be described; areas where there is substantial potential for change will be identified and policy issues associated with potential changes will be discussed.

One important value of these studies already apparent is their catalytic effect in stimulating dialogue among institutional officials with diverse information handling needs and responsibilities. These discussions are leading to new perspectives on the possibilities for greater intra-institutional cooperation and coordination of related tasks.

Teaching Hospitals

The Association's teaching hospital activities were concentrated in six areas during 1980–81: the budget reconciliation acts of 1980 and 1981; health care competition; legislative and regulatory analysis; house staff unionization; a major study of teaching hospitals; and surveys and publications.

For the first time in the Congressional budget process, a House-Senate conference committee began work in mid-September 1980 to resolve differences between two versions of a budget reconciliation bill for trimming the federal government's budget for fiscal year 1981. In this process, AAMC supported a provision in the House bill that would repeal Section 227 of the Social Security Act, the highly controversial Medicare provision which discriminated against physicians caring for patients in teaching hospitals. The Association opposed certain provisions in the Senate bill relating to Medicaid and Medicare which would have been harmful to teaching hospitals. The final budget reconciliation act signed by President Carter contained many Medicare-Medicaid reimbursement reforms, including the AAMC-supported provision which repealed Section 227 of the 1972 Social Security amendments and added new guidelines for paying teaching physicians. The amendment did retain the original Section 227 provision allowing cost reimbursement when elected by all physicians in the hospital. While the list of Medicare-Medicaid amendments was extensive, the House-Senate conferees dropped from the final measure four of the five controversial provisions strongly opposed by the AAMC.

President Reagan's fiscal year 1982 proposed budget called for the imposition of an "interim cap" to limit federal payments under the Medicaid program to $100 million less than the current spending estimate for fiscal year 1981, with a five percent increase above this amount in fiscal year 1982. Increases beyond that fiscal year would simply be adjustments for inflation. In return for the reduction in federal support, states would be given increased control over Medicaid eligibility, benefits and reimbursement policies.

To assist in the development of its position, strategy, and testimony concerning the Administration's Medicaid proposal, and to help substantiate the significant role teaching hospitals have in caring for Medicaid patients and the importance of adequate payment for these services, the Association surveyed its teaching hospital members on their Medicaid activities. Citing preliminary statistics from the survey, the Association testified before the Senate Committee on Finance on the proposed Medicaid cap and emphasized that the Administration's proposal would have several adverse effects on teaching hospitals. These included increased hospital bad debts and charity requirements, increased hospital financial distress, increased hospital prices for charge-paying patients, a reversal of hospital accomplishments in providing a one-class standard of care, and creation of a serious barrier to the Administration's interest in competition. The Association urged the Committee to reject the proposed Medicaid budget reductions and to examine other areas of the proposed federal budget where reductions would not have the devastating impact of Medicaid program cutbacks. In addition, the AAMC strongly opposed a denial-of-choice provision which would give the HHS Secretary the authority to permit states to mandate, on a least cost basis, a Medicaid recipient's physician and hospital.

Throughout the spring the AAMC conveyed to members of Congress its opposition to various proposed Medicaid and Medicare budget cuts. Written testimony was submitted to the House Health Subcommittee on the Medicaid component on the Administration's proposed "Health Care Financing Amendments of 1981," which contained the legislative language necessary to implement the proposed federal cap. After careful consideration of the provisions of the House and Senate reconciliation

bills, the AAMC Executive Council concluded that the House bill was preferable in most respects to the Senate bill. However, the Association targeted certain Medicare and Medicaid provisions in the House version for opposition. The final reconciliation package signed by President Reagan included milder forms of some of the provisions opposed by teaching hospitals. The Administration's proposed Medicaid cap was replaced by reductions of 3 percent in federal Medicaid funding in fiscal year 1982; 4 percent in 1983; and 4½ percent in 1984. These reductions could, however, be minimized or eliminated entirely if certain specified criteria are met by the state.

Since the defeat of President Carter's hospital cost containment legislation in 1979, increasing attention has been given to ways of injecting price competition into the health care marketplace to stimulate cost consciousness among providers and consumers. Many advocates see the competitive approach as an alternative to regulations and mandatory controls on health care costs. An AAMC *ad hoc* Committee on Competition met to explore the implications of price competition for teaching hospitals. Its draft report was accepted by the Executive Council and developed into a monograph, "Price Competition in the Health Care Marketplace—Issues for Teaching Hospitals." This widely distributed document raises important issues that must be understood and addressed in the debate on competition legislation. Advocates of price competition recognize that teaching hospitals have multiple products which benefit not only individual patients, but society as a whole. The commonly offered solution is to identify and publicly fund these additional activities based on their own merits. However, the AAMC has emphasized that attempts to segment the unique characteristics of teaching hospitals into measurable units risk ignoring that their contributions are the products of inter-related programs, which together provide the environment and resources required for teaching future health manpower and advancing medical knowledge and practice.

In 1980 the Senate Subcommittee on Health and Scientific Research considered two bills to provide assistance to financially failing hospitals. The AAMC provided testimony for the hearing record in support of the bills wi certain modifications. Of particular concer was the effect of the hospitals' fiscal stringen cies on their graduate medical education pro grams.

The AAMC agreed that federal action wa necessary to adequately address the problem Noting that hospitals which serve large num bers of medically indigent and poor patient need long-term solutions which modify the fi nancing of health services for those popula tions, the AAMC urged immediate, extern assistance that could include modifications i Medicare Section 223 limitation procedure Medicare and Medicaid participation in hos pital bad debts, special project funds to mod ernize facilities, and special project grant pr grams for hospital operations. While support ing both pieces of legislation as interim, emer gency measures for transitory relief to finan cially troubled hospitals on the brink of closure the AAMC emphasized that without long-ter reforms to address the inequities of curren reimbursement policies and the gaps in healt insurance coverage, these measures would d little more than temporarily veil the continuin threat of bankruptcy and closure for these hos pitals.

While such legislation was eventually table the Health Care Financing Administratio published a notice soliciting applications fro state Medicaid agencies for demonstratio projects to improve the efficiency of service and management in financially troubled hos pitals in medically underserved rural and inner city areas. Under this program HCFA grante $11 million for health maintenance organiza tion/hospital oriented projects at teaching ho pitals in Boston, Jacksonville, and Los Angele

The Association commented on propose HCFA regulations making changes to the Con ditions of Participation for Hospitals under th Medicare and Medicaid programs. While ge erally supportive of the potential for allowin hospitals greater flexibility in performing ad ministrative and managerial functions, the A sociation identified a number of areas of cor cern and presented comments and recommer dations regarding 52 technical issues.

The AAMC also commented on propose HCFA regulations establishing incentive rei bursement for outpatient dialysis and self-ca

dialysis training. The Association noted that the proposed regulations recognized and provided for different reimbursement rates for hospital-based and independent (free-standing) dialysis services, and urged this distinction be retained. The AAMC was concerned, however, that the proposed regulations included a detailed statistical methodology for calculating the incentive reimbursement rate in the admitted absence of adequate data. The Association asked HCFA to delay promulgation of incentive reimbursement rates until appropriate data could be collected and the impact of the rates on beneficiaries and providers could be analyzed.

In the area of health planning, the Office of Management and Budget proposed establishing policies and procedures to halt federal financial support for hospital construction in overbedded areas. The AAMC expressed several concerns about the memorandum, foremost being its disregard for the capabilities of the existing health planning structure to monitor hospital construction. The incoming Reagan Administration later rescinded the OMB memorandum.

Final regulations were issued establishing the minimum requirements for satisfactory certificate of need review programs under amendments to the health planning law. A major concern about the status of proposed capital expenditures or major medical equipment acquisitions for research and training was addressed in the final CON regulations, which emphasized that: "Only clinically related services are included in the definition of institutional health services; consequently, research services *per se* are not required to be subject to review. Capital expenditures are required to be reviewed only if they are made by or on behalf of the health care facility. Major medical equipment acquired for research purposes need not be subject to review if the equipment will not be used to provide services to inpatients of a hospital."

The Health Programs Extension Act of 1980 also contained several health planning amendments. The AAMC worked closely with Congressional staff to develop an amendment providing an exception to the existing CON requirements for the acquisition of major medical equipment, provision of institutional health services, or the obligation of capital expenditures undertaken solely for purposes of research.

The AAMC commented on the proposed national health planning goals on health status outcomes, disease prevention and health promotion, and institutional and personnel resources. The Association criticized the planning goals as lacking a sense of realism and consistency, for there was no discussion of the cost and funding implications of pursuing such goals. The Association also emphasized that it was the expressed intent of Congress that decisions about applicability of the goals and standards be made at the local level. A final version of these goals has yet to be published. Regarding the future of the overall health planning program, the AAMC's Executive Council identified several critical deficiencies of the program and its implementation and did not make the planning act a priority for Association action.

In July 1980, the U.S. Court of Appeals for the District of Columbia Circuit ruled that the National Labor Relations Board acted within its statutory authority in its March 1979 *Cedars-Sinai* decision which declared that interns and residents are primarily students rather than employees for coverage under the National Labor Relations Act. The AAMC was *amicus curiae* in the case supporting the NLRB's position, as well as in the original *Cedars-Sinai* case. The Court of Appeals case was brought by the Physicians' National Housestaff Association after an earlier U.S. District Court decision concluded the court had no jurisdiction to review the NLRB's decision. The case, *PNHA v. John H. Fanning et al.*, was then appealed to the U.S. Supreme Court, which denied the motion and left standing the lower court determinations.

During the past year the AAMC participated as *amicus curiae* before the Federal Labor Relations Authority in two cases in which PNHA sought to represent house staff enrolled in graduate medical education programs at Veterans Administration medical centers. The Association also submitted *amicus curiae* briefs before the California Public Employment Relations Board, in a case considering unionization for house staff at hospitals owned and operated by the state, and the NLRB, in the case of *Children's Hospital of Los Angeles v. Interns and*

Residents Association of Children's Hospital. The outcomes of these cases are pending.

The COTH Spring Meeting included a progress report on the Association's major descriptive study of teaching hospitals. With guidance from the *ad hoc* Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, the Association's staff developed a methodology for the study. Thirty-three COTH member hospitals submitted a computer tape of their fiscal year 1978 patient discharge abstracts and bills. In addition, hospitals supplied Medicare cost reports, audited financial statements, annual reports, and patient origin studies. Finally, questionnaires on educational programs, hospital staffing and patient services were completed by the study hospitals. During 1980–81 staff completed a major portion of the analysis of the data received. The patient abstract and billing information for more than 500,000 patient records has been analyzed using two case mix measures: diagnosis related groups and disease staging. Data from the three questionnaires and other hospital reports are being prepared for a final report, expected to be available in early 1982. It will present findings on facilities and services, educational programs, hospital staffing, financial characteristics, and patient case mix.

In June 1981, the Association staff completed an analysis of construction projects begun in 1979 among COTH non-federal member hospitals. It was found that 68 percent of the funding of such projects was financed by some form of debt, a dramatic change from 1969 when only 20 percent of such capital was borrowed or financed through debt. Results of the latest survey, which were compared with the pattern of funding for construction projects begun in 1974 and those completed in 1969, were presented in the *COTH Report*, a comprehensive hospital issues-oriented newsletter published ten times annually.

In addition to the newsletter, the Association has maintained its program of regular membership reports and surveys. The Association distributed a revised version of the paper entitled "Toward A More Contemporary Public Understanding of the Teaching Hospital," originally presented at the 1979 COTH Spring Meeting. *The COTH Directory of Educational Programs and Services* was published for the thirteenth consecutive year, providing an operational and educational program profile of each COTH member. House staff stipend and fringe benefit information was again published in the *COTH Survey of House Staff Stipends, Benefits, and Funding.* The Association also published datagrams in the *Journal of Medical Education* on the topics of teaching hospital construction funding, university-owned teaching hospital income, and house staff compensation and funding.

Communications

During the year the AAMC 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.

More than 20 news media interviews and requests for information and policy statements are initiated or responded to by AAMC staff each week. This media interaction has, in part, been responsible for the editors of *U.S. News and World Report*, for the fifth consecutive year, naming the Association's President "as one of the five most influential leaders in the health field in the U.S." In compiling their list of influential persons in several categories, *U.S. News and World Report* surveys journalists, Capitol Hill staffers and members of Congress.

The most important publication used by the Association to inform its constituents is the *President's Weekly Activities Report*. This report, which is issued 43 times a year and reaches about 9,000 readers, reports on AAMC activities and federal activities that have a direct effect on medical education, biomedical and behavioral research, and health care.

The *Journal of Medical Education* in fiscal year 1981 published 1,045 pages of editorial material in the regular monthly issues, compared with 1,039 pages the previous year, including 88 regular articles, 72 Communications, and 10 Briefs. The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1980–81 totaled 421; 130 were accepted for publication, 203 were rejected, 10 were withdrawn, and 78 were pending as the year ended. The *Journal's* monthly circulation averaged about 6,500, an increase of 100 compared with 1980. During the year, special issues were devoted to geriatrics and medical education and to the AAMC Annual Meeting plenary session addresses. The AAMC's Annual Report and Annual Meeting program were published as a supplement.

About 32,000 copies of the annual *Medical School Admission Requirements*, 4,500 copies of the *AAMC Directory of American Medical Education*, and 8,000 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 AAMC.

The *COTH Report* is the newsletter of the Association's Council of Teaching Hospitals. It is published 10 times annually and is distributed to more than 2,600 subscribers. The newsletter provides a comprehensive review of Association and COTH activities; federal legislative and regulatory issues of relevance to the academic medical/teaching hospital community; pertinent surveys, studies, reports and other publications; and current health care topics of interest. Other newsletters include the *OSR Report*, which is circulated twice a year to medical students; *STAR* (Student Affairs Reporter), which is printed twice a year and has a circulation of 1,000; and the *Council of Academic Societies Brief*, which is published four times a year and has a circulation of 5,000.

Information Systems

The Association has a general purpose computer system to support its information requirements. This in-house system facilitates the optimum use of the Association's information resources for its programs. The development and use of the information systems have increased significantly during the past year, and the Association's activities are now enhanced by comprehensive student, faculty, and institutional data systems.

The information systems on medical students continue to develop and expand. Work continues on a unified system to monitor students from their pre-medical years through the application process, medical school, and into the first years of post-M.D. experience. This system will provide the basis for both historical perspective and current information on medical students in the United States.

The heart of the medical student information system is the American Medical College Application Service system. This system supports the Association's centralized application service by capturing data on applicants to medical school and linking applicant data with the MCAT test scores and academic record information for each applicant. Medical schools and applicants are informed of the application process through daily status reports, and medical schools regularly receive rosters of applicants and summary statistics which compare their applicants with the national applicant pool. Each applicant's record is immediately available via computer terminal to appropriate Association personnel responding to telephone inquiries from applicants and medical school personnel.

The information in the AMCAS system is the basis for special reports generated throughout the year and provides answers to questions posed by medical school personnel and Association staff. The AMCAS system is also used for regular descriptive studies of medical school applicants as well as more focused, issued-oriented studies.

A number of other data systems supplement the AMCAS information on medical students. Among these are the Medical College Admission Test reference system, which contains MCAT score information for all examinees; the college system, which contains information on all U.S. and Canadian colleges and universities; and the Medical Sciences Knowledge Profile system on individuals applying to take the MSKP exam for advanced standing admission to U.S. medical schools.

Information on students enrolled in U.S. medical schools is maintained in the student records system. This system, maintained in cooperation with the medical schools, follows the progress of medical students from matriculation through graduation. The information in the student records system is supplemented periodically through the administration of surveys, such as the Graduation Questionnaire and the financial aid survey, to specific groups or samples of medical students.

The Association maintains two major information systems 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. This information is maintained in cooperation with medical school staff by Association personnel having online access and capability to update the information. Data in the Faculty Roster system are periodically reported to the medical school in summary fashion, enabling the schools to obtain an organized, systematic profile of their faculty. The faculty salary survey system contains information from the Association's annual survey of medical school faculty salaries. This information is used for the annual report on medical school faculty salaries and is available on a confidential, aggregated basis in response to special inquiries from the schools.

The Association maintains a number of institutional information systems, including the

Institutional Profile System, a repository for information on medical schools. Information is entered both directly from surveys sent to the medical schools and through other information systems, from which data are aggregated by medical school. The information is maintained in a data base supported by a software package that allows immediate user retrieval via computer terminal. The system is used to respond to requests for data from medical schools and other interested parties, and to support a variety of research projects. There are over 20,000 items of information currently in IPS describing many aspects and characteristics of medical schools from the early 1960s through the present.

An ancillary system to the Institutional Profile System has been developed to process Part I of the Liaison Committee on Medical Education annual questionnaire. This allows data input and on-line editing of the data, and generates reports that identify errors and inconsistencies in the data on the questionnaires and compare the values from the current year with those reported from the previous four years. This system produces information used in the report of medical schools' finances which appears in the annual education issue of the *Journal of the American Medical Association.*

Information on the teaching hospitals is also maintained. The Association's program of teaching hospital surveys combines four recurring surveys with special issue oriented surveys. The annual surveys are the educational program and services survey, the house staff policy survey, the income and expenses survey for university-owned hospitals, and the executive salary survey. These serve as the basis of four annual reports generated by the Association and provide answers to special requests made by the member hospitals.

Data collection and information dissemination efforts of the Association continue to give attention to special areas or issues of concern to medical education. Among the areas currently receiving focused attention are the status of women in academic medicine, the status of medical practice plans in the medical schools, and the case mix of patients in teaching hospitals. The Association staff will continue to use all available information resources to focus on these and other areas of importance to academic medicine.

AAMC Membership

Type	1979-80	1980-81
Institutional	116	123
Provisional Institutional	10	3
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	18	18
Academic Societies	69	71
Teaching Hospitals	423	410
Corresponding	40	28
Individual	1,384	1,301
Distinguished Service	48	52
Emeritus	62	50
Contributing	15	4
Sustaining	14	12

Treasurer's Report

The Association's Audit Committee met on September 4, 1981, and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1981. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 11, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $9,474,657. Of that amount $8,034,218 (85%) originated from general fund sources; $241,112 (2%) from the foundation grants; $1,199,327 (13%) from federal government reimbursement contracts.

Expenses for the year totaled $8,726,381 of which $7,074,083 (81%) was chargeable to the continuing activities of the Association; $293,099 (3%) to foundation grants; $1,199,327 (14%) to federal cost reimbursement contracts; $159,872 (2%) to Council designated reserves. Investment in fixed assets (net of depreciation) increased $270,228 to $1,020,163.

Balances in funds restricted by the grantor increased $100,210 to $470,996. After making provisions for reserves in the amount of $250,000 principally for special legal contingencies and MCAT and AMCAS development unrestricted funds available for general purposes increased $80,357 to $6,775,972, an amount equal to 78% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintains as a goal an unrestricted reserve of 100% of the Association's total annual budget. It is of continuing importance that an adequate reserve be maintained.

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.

Association of American Medical Colleges
Balance Sheet
June 30, 1981

ASSETS		
Cash		$ 8,852
Investments		
Certificates of Deposit		11,148,085
Accounts Receivable		715,356
Deposits and Prepaid Items		51,052
Equipment (Net of Depreciation)		1,020,163
Total Assets		$12,943,508
LIABILITIES AND FUND BALANCES		
Liabilities		
Accounts Payable		$ 776,567
Deferred Income		1,765,805
Fund Balances		
Funds Restricted by Grantor for Special Purposes		470,996
General Funds		
Funds Restricted for Plant Investment	296,856	
Funds Restricted by Executive Council for Special Purposes	1,837,149	
Investment in Fixed Assets	1,020,163	
General Purposes Fund	6,775,972	9,930,140
Total Liabilities and Fund Balances		$12,943,508

Association of American Medical Colleges
Operating Statement
Fiscal Year Ended June 30, 1981

SOURCE OF FUNDS	
Income	
Dues and Service Fees from Members	$2,456,689
Grants Restricted by Grantor	241,112
Cost Reimbursement Contracts	1,199,327
Special Services	3,647,896
Journal of Medical Education	79,675
Other Publications	325,627
Sundry (Interest $1,172,326)	1,524,331
Total Income	$9,474,657
Reserve for Special Legal Contingencies	50,000
Reserve for CAS Services Program	–0–
Reserve for Special Studies	11,809
Reserve for Minority Programs	–0–
Reserve for Patient Intensity Program	39,757
Reserve for Personal Assessment	31,031
Reserve for House Staff Meetings	27,275
Total Source of Funds	$9,634,529
USE OF FUNDS	
Operating Expenses	
Salaries and Wages	$4,035,707
Staff Benefits	599,452
Supplies and Services	3,180,592
Provision for Depreciation	209,314
Travel and Meetings	697,730
Loss on Disposal of fixed assets	3,586
Total Expenses	$8,726,381
Increase in Investment in Fixed Assets (Net of Depreciation)	270,228
Transfer to Executive Council Reserved Funds for Special Programs	250,000
Reserve for Replacement of Equipment	207,353
Increase in Restricted Fund Balances	100,210
Increase in General Purposes Fund	80,357
Total Use of Funds	$9,634,529

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