Association of American Medical Colleges
Annual Meeting
and
Annual Report
1980

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Chairman's Address

Past and Prologue

Charles B. Womer

All of us, at the 1979 Annual Meeting and at other forums, have heard eminent speakers discuss the crucial issues and challenges facing academic medical centers, hospitals, and the health care field generally. The immensity, complexity, and seeming insolubility of many of these issues motivated me to look back 50 years to the early 1930s to determine what the prognosticators said then about the issues and challenges facing academic medical centers and the health care field. The similarities that I found were surprising, occasionally disturbing, but mostly reassuring.

In 1930 we were a nation of 48 states and 123 million people. Herbert Hoover was in the second year of his presidency and Dr. Ray Lyman Wilbur, president of Stanford University and former president of both the AAMC and the AMA, was Secretary of the Interior. Despite the fact that the nation and world were sliding into the Great Depression, Prohibition, not the economy, was the issue of greatest debate and controversy both in the Congress and the nation at large, just as it had been throughout the "roaring twenties."

During much of 1930 President Hoover, his cabinet members, and many economists expected the economy to recover soon. Indeed, during the first quarter of the year the stock market experienced a "little bull market" and the industrial indices improved. In March the President predicted that unemployment would be over in 60 days, and in late May he predicted that business would be normal by fall. As late as August 30, the Weekly Letter of the Harvard Economic Society stated that "the present depression has about spent its force." (1) The unemployment rate for 1930 was 8.7 percent, up from 3.2 percent in 1929. It reached a high of 24.9 percent in 1933.

Fifty years ago Amos 'n Andy were the hits of radio, Ethel Merman was playing in "Girl Crazy" on Broadway, and Robert Montgomery was starring in the early talking movie, "War Nurses." Women's skirts were lengthening, the red hot flapper was disappearing, and the previous decade's preoccupation with sex was diminishing.

Backward Look

Fifty years ago the AAMC held its 41st Annual Meeting in the Outpatient Department of the University of Colorado School of Medicine. The membership consisted of 72 of the 76 U.S. medical schools, three Canadian schools, and three graduate or postgraduate schools. The admission of two additional schools, Duke University and the University of Rochester, was approved at the meeting as was an increase in dues from $100 to $250 per year. The dues were subsequently reduced to $150, and $100 was refunded to each of the members. The staff of the AAMC consisted of the secretary-treasurer, Fred C. Zapffe, M.D., who served in that capacity from 1898 until 1948, and a part-time secretary. Expenses for fiscal year 1930 were $8,531. This included the $3,553 cost of

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This paper was delivered at the October 28, 1980, plenary session of the 91st Annual Meeting of the Association of American Medical Colleges, Washington, D.C.

Mr. Womer, president of University Hospitals of Cleveland, was the 1979–80 chairman of the AAMC

publishing the bimonthly *Journal of the Association of American Medical Colleges.* The expense budget for the current fiscal year is over $7 million.

In 1930 the 76 U.S. medical schools admitted 6,400 students, less than 4.5 percent of whom were women, and graduated 4,565 students. The total budget of all U.S. and Canadian schools was approximately $13 million. This had increased to $4.916 billion in 1978–79.

Most of the major national health issues of the late 1920s and early 1930s were addressed by one or both of two distinguished groups. The first formed was the Commission on Medical Education, which was organized in 1925 by the Association of American Medical Colleges to "make a study of the educational principles involved in medical education and licensure, and to make suggestions which would bring them into more satisfactory relationships with the new conceptions and methods of university education, on the one hand, and with the needs of present day society, on the other." (2) The chairman of the 17 member commission was A. Lawrence Lowell, L.L.B., Ph.D., president of Harvard University, and the director of study was Willard C. Rappleye, M.D., former superintendent of the New Haven Hospital, who in 1931 was appointed dean of Columbia University's College of Physicians and Surgeons. The commission's work was financed by donations from medical schools, the AMA, the Carnegie Corporation, and the Rockefeller and Josiah Macy, Jr. foundations.

The second distinguished group, the Committee on the Costs of Medical Care, was formed in 1928 "to carry on an extensive program of research in the various economic aspects of medical care." (3) "Medical care" was defined broadly to encompass virtually all aspects of health care delivery. This 50 member committee was chaired by the previously mentioned Ray Lyman Wilbur, M.D., Secretary of the Interior and president of Stanford University, and its director of study was Harry H. Moore, Ph.D. The committee published 26 research reports during its five-year existence. It was supported by eight foundations, including the Josiah Macy, Jr. Foundation, Millbank Memorial Fund, Rockefeller Foundation, and Carnegie Corporation.

In its final report in 1932, the Commission on Medical Education stated:

> The rapid growth in knowledge and the changes in social organization in recent years have greatly complicated the problems of medical service. . . .
>
> There is general agreement that the greatest health problem in the country at the moment is that of securing an adequate distribution of modern medical services to the entire population at a reasonable cost to the individual and the community. It is clear that present-day knowledge of the diagnosis, treatment, and prevention of disease is far in advance of its application to the needs.

The report of the Committee on the Costs of Medical Care stated much the same thing in a different way:

> Yet medical science has made marvelous advances during the last fifty years. Following the work of Pasteur, Lister and Koch remarkable progress has been made in controlling the communicable diseases, and the average length of life during this period has been greatly extended. . . . We have the knowledge, the techniques, the equipment, the institutions, and the trained personnel to make even greater advances during the next fifty years. We know how to do many things which we fail to do or do in an incomplete and often most unsatisfactory manner. As a result of our failure to utilize fully the results of scientific research, the people are not getting the service which they need—first because its cost is beyond their reach, and second, because in many parts of the country it is unavailable. The costs of medical

care have been the subject of much complaint.

The report of the Commission on Medical Education lamented, "There is some danger that public thinking has been maneuvered into an unfortunate position recently in regard to this whole matter, for emphasis is being placed upon the present organization and cost of medical care, rather than upon the support of an adequate medical service of high quality."

Issues in 1930

Thus, 50 years ago we had the familiar condition of rapidly advancing medical science together with the problems of dissemination of modern medical knowledge and high medical care costs. This was at a time when the average per capita health care cost was approximately $30 per year and total national health expenditures were $3.6 billion or 3.5 percent of the gross national product. In 1979 per capita cost was $943 and total national health expenditures $212 billion, 9 percent of the gross national product.

The two reports cited much waste in the health-care delivery system including, but not limited to, the annual expenditure of $360 million for patent medicines and $125 million for services of cult practitioners, excessive laboratory and X-ray examinations, diagnosis by exclusion, duplication, and underutilization of facilities among hospitals and between hospitals and physicians' offices, low hospital occupancy, absence of community planning and integration of facilities and services, and the public's desire to have the latest and best within reach of everyone.

The Committee on the Costs of Medical Care concluded that national health care expenditures were not excessive in view of the national expenditures for tobacco, toilet articles, recreation and automobile use and predicted that " . . . in the next two or three decades, far larger amounts will be spent advantageously and without hardship." The Commission on Medical Education cited the need for increased expenditures to make high quality care more readily available.

There also were significant issues in undergraduate medical education in the early 1930s. The efficacy of the various methods of evaluating applicants to medical schools was a warmly debated one. In 1930 all of the 76 medical schools in the nation required two years of college preparation for admission and two required a degree. This was considered a great improvement over 1900 when only five of 165 schools required any college work. There was great interest in improving the selection of applicants. Although there were over two applicants per student matriculated, the average attrition rate was over 20 percent, due largely to failures and withdrawals during the first year. In 1929 the AAMC established a committee to study the aptitude test it sponsored. The committee gave a comprehensive report at each Annual Meeting between 1930 and 1934, following which the participants debated the efficacy of the test. At the 1930 Annual Meeting a test opponent facetiously expressed concern that the proliferation of tests and application forms would result in a great shortage of wood pulp. Despite the fact that the committee reported a high correlation between test results and success in medical school, the controversy was so heated that the Executive Council at the 1934 Annual Meeting recommended that the test be discontinued while a detailed study of it was made. The membership approved the study but rejected the discontinuance.

The undergraduate medical school curriculum was found wanting by the Commission on Medical Education and others who examined it in the early 1930s. Dr. Maurice H. Rees in his President's Address

at the 1931 Annual Meeting found it oriented too much toward producing specialists, overstressing scientific education and neglecting the art of medicine, ignoring the field of medical economics, and needing improved courses in medical ethics. (4)

Among the observations of the Commission on Medical Education were the following which have a familiar ring:

> Some of the chief difficulties in medical training arise from efforts to provide instruction in too many subjects in too great detail. These endeavors have created great overloading of the curriculum. The dependence upon sheer memory tends to defeat a scientific attitude and point of view.... The methods of presenting subjects, both in the medical sciences and in the clinical departments, are often unsatisfactory. Teachers, graduates, and students agree that topics are presented too frequently from the standpoint of the special interest of the teacher and from the aspect of technical details.
>
> The chief criticism of the clinical instruction is that it is often focused on the rare and serious diseases requiring the services of specialists and advanced laboratory determinations for diagnosis and treatment. The presentation of many such problems and the emphasis upon the specialized services required for the study of such conditions gives the student an erroneous idea of the medical problems in the community at large, and of the equipment and procedures required for practice.... Too often the diffusion of responsibility for the care of the patient makes for the impersonal consideration of the individual.

Both the Commission on Medical Education and the Committee on Medical Care Costs recommended that much greater emphasis should be placed on the teaching of preventive medicine, the latter group saying, "Such emphasis should not be confined to special courses in public health or preventive medicine but should, as far as possible, permeate all courses. This involves reorientation of the entire curriculum."

Incidentally, the 1931 Annual Meeting of the AAMC, which I mentioned a moment ago, was held in New Orleans, and members were offered a nine-day tropics cruise "aboard one of the beautiful steamers of the Great White Fleet of the United Fruit Company," which sailed immediately after the last session. The cost, first class, all expenses: $95 per person.

Foreign Medical Graduates

I was surprised to learn that foreign medical graduates and U.S. citizens studying in foreign medical schools were significant issues in the early 1930s. The FMG problem was particularly pronounced in the state of New York where almost 25 percent of the applicants for licensure were foreign medical graduates and about half of them failed the licensure examination.

The number of American students in foreign medical schools increased from 977 in 1930 to 1,911 in 1932, a number equal to almost 10 percent of the total enrollment of U.S. medical schools. Most were enrolled in European schools, only one in Mexico, and none in the Caribbean. They enrolled in the foreign schools for the same reasons as today—they could not get into, or they failed in, U.S. schools.

This problem was quickly resolved in 1933 in a manner that probably would make Justice Department antitrust lawyers salivate if it were to be attempted today. Prodded by an AAMC resolution at the 1932 Annual Meeting, a meeting of representatives of the AAMC, AMA, Federation of State Medical Boards, National Board of Medical Examiners, and the Board of Regents of the State University of New York met in February 1933 to consider the issue. Upon recommendation of this group, the Federation of State Medical Boards adopted a resolution which

stated that no American student matriculating in a European medical school after 1932 would be admitted to any state licensing examination or to the NBME examination who did not, before matriculating, obtain from a State Board of Medical Examiners a certificate endorsed by the AAMC or the Council on Medical Education and Hospitals of the AMA showing that he had met their premedical educational requirements. Also, no FMG, either European or American, would be admitted to a licensure examination unless he met the same premedical requirements and had a license to practice in the country in which he attended medical school. That last provision was the valve that shut off the flow—Great Britain was the only European nation which granted licenses to noncitizens.

By this time it probably will be no surprise to any of you that physician oversupply and geographic and specialty maldistribution were major health issues of the early 1930s. U.S. medical schools were graduating slightly under 5,000 students per year, compared to about 16,000 today. The nation had approximately 156,000 physicians or one per 790 population compared to approximately 440,000 physicians or one per slightly over 500 population today. However, the Commission on Medical Education estimated the 1932 physician oversupply to be at least 25,000, and its report stated, "It is clear that in the immediate past there has been a larger production than necessary and that at the present time we have an oversupply of physicians, although they are not well distributed in relation to the population and to the medical needs of certain areas."

Supply and Distribution

The commission made a detailed projection of the future number of physicians and the growth of the population. It predicted that if 5,400 new physicians were added to the profession each year, the nation would have between 206,000 and 212,000 physicians by 1980; and with a projected 1980 population of 147,000,000, the physician/population ratio would be one per 700. It cited ratios in Europe ranging from 1 per 880 in Austria to 1 per 2,890 in Sweden. The commission warned:

> If the present rate of supply is continued, the numbers of physicians in excess of indicated needs will increase.... Those responsible for medical education and for the licensure of physicians, particularly for graduates of foreign medical schools, should have this situation clearly before them.

I shudder when I think of the predicament we would be in today if the academic community or government had heeded the commission's warning and had taken action to restrict the supply of physicians.

What was wrong with the commission's projections? Obviously, the population projections were far too low. Our population of about 221,000,000 represents an 83 percent increase over 1930 instead of the 21 percent estimated then. But even if the population had been estimated accurately and the physician/population ratio had been held to 1930's "oversupply" level of one to 790, we would have 280,000 physicians today, about the number we had in the critical shortage years of the early 1960s. The prognosticators of 1930 either did not realize, or forgot, that it usually requires additional manpower to make medical advances generally available to the people and that the increased life expectancy brought about by these advances increases the demand for medical services. One cannot help but wonder if the prognosticators of oversupply today are making similar miscalculations.

Incidentally, in a discussion of physician oversupply at the 1934 AAMC Annual Meeting, Dr. William Pepper (5) of the

University of Pennsylvania stated, "I wonder, now that money is being given out for not raising hogs, whether we could not get some money from the government for not turning out so many doctors." I hope it does not disappoint those of you who have been proposing much the same thing recently to learn that the idea is at least 46 years old.

In regard to geographic maldistribution, the Committee on the Costs of Medical Care reported that in 1929 there was one physician for every 1,413 persons in South Carolina, one for every 571 in California, and one for 621 in New York. The Commission on Medical Education concluded:

> All recent studies of this question agree that the greater opportunity in the cities for financial rewards and better opportunities for practice are the outstanding causes of the tendency of physicians to locate in the cities. Changes in the character of medical practice require facilities which the cities are more likely to provide. In many of the small communities adequate hospital and other inducements for the modern practice of medicine have not been available. This situation, however, is gradually correcting itself and the problem of securing satisfactory medical services for most rural districts is being solved.

Today, 50 years later, we hear the same thing.

Specialty maldistribution was a two-pronged issue in the early 1930s. The Committee on the Costs of Medical Care observed that "approximately 45 percent of the physicians of the country have completely or partially limited their practice to a specialty, although apparently the needs of the people could be met adequately if not more than 18 percent of physicians were specialists." The other aspect of the issue was that a large number of the specialists were self-labeled specialists who were inadequately trained to practice their specialties, something that is much less common today.

Conclusion

I don't want to give you the impression that all of the health issues of 50 years ago were the same as those we face today—only that many of the most important were. For instance, physicians' incomes were a concern then as now, but the concern was that most were too low. There was a significant oversupply of nurses, and the issues in graduate medical education were very different than they are today. In my opinion the most striking difference is the fact that 50 years ago the federal government was not trying to solve our problems for us, and few responsible voices were clamoring for it to step in and do so. A large majority of the Committee on the Costs of Medical Care believed that the federal government should be prepared to provide financial aid only if the family, community, and state, in that order, were unable to carry the financial burden of care.

Undoubtedly there are some among you who are thinking that the issues and problems of 50 years ago may have had many of the same labels as those of today, but the 1930s were much simpler times and the issues and problems were of a much lower order of complexity. That could well be true, but society's capacity to address and solve complex issues and problems in the early 1930s was also much less than our capacity to do so today. Also, we have the benefit of 50 years' added experience in working on many of them and, of course, the invaluable assistance of our federal bureaucracy, Congress, and state governments.

Some of the issues and problems we face today have persisted throughout the past half century and even longer, and undoubtedly will continue to persist far into the future. Some are on carousels and will come and go periodically just as the issue of physician oversupply came, went, and has returned. The issues and problems we

face may seem immense, complex and, in some cases, insoluble. But I was reassured by my look backwards. Many of the issues and problems of today may be the same as they were in the 1930s, but we have made tremendous progress over the past 50 years in almost every aspect of medical education, research, and delivery of care.

The first chairman who will be able to view the early 1980s from the same perspective that I have had of the 1930s will be your chairman in 2030. I don't expect to listen to her or his address; but if I were a betting man, I would bet that if she or he takes the same tack as I have, she or he too will point to many of the same issues that I have discussed today, will look back on the last 50 years as years of tremendous progress, and will view the future with concern as I think most of us do today. That is good, for our remarkable progress in medical research, education, and delivery of care will continue only as long as we recognize that there are significant issues to be addressed and we are willing to address them.

References

1. GALBRAITH, J. K. *The Great Crash of 1929* (Second Edition). Boston, Massachusetts: Houghton-Mifflin, 1961.
2. LOWELL, A. L. (Chairman). *Final Report of the Commission on Medical Education.* New York: Office of the Director of Study, 1932.
3. WILBUR, R. L. (Chairman). *Final Report of the Committee on the Costs of Medical Care.* New York: Arno Press, 1972.
4. REES, M. H. President's Address. *J.A.A.M.C.*, **7**:1–4, 1932.
5. Forty-fifth Annual Meeting of the Association of American Medical Colleges. *J.A.A.M.C.*, **9**:328, 1934.

The Ninety-First Annual Meeting

Washington Hilton Hotel, Washington, D.C., October 25–30, 1980

Theme: The New Biology and the Future of Medical Education

Program Outlines

PLENARY SESSION

October 27

Presiding: Charles B. Womer

High-Powered Research and the Microscopic Viewpoint
DeWitt Stetten, Jr., M.D.

BURROUGHS WELLCOME FUND LECTURES:
Advances in Neurobiology
Eric Kandel, M.D.
The New Genetics
Philip Leder, M.D.

ALAN GREGG MEMORIAL LECTURE:

Science, Medicine and Medical Education
Daniel C. Tosteson, M.D.

October 28

Presiding: Julius R. Krevans, M.D.

Presentation of Borden and Flexner Awards

Keynote Address

The Medical University
Gerard Piel, D.Sc.

Past and Prologue
Charles B. Womer

SPECIAL GENERAL SESSION

October 28

BIOMEDICAL TECHNOLOGY: ITS IMPACT ON MEDICAL EDUCATION AND MEDICAL PRACTICE

Moderator: Charles A. Sanders, M.D.

Introduction of New Medical Technology into Medical Practice—Who Pays?
Robert H. Ebert, M.D.

New Technologies, New Costs?
Walter J. McNerney

Perspectives on the Use of Medical Technology: Benefits, Costs, and Incentives
Steven A. Schroeder, M.D.

COUNCIL OF ACADEMIC SOCIETIES

October 26

CAS FORUM ON FACULTY
Changes in Characteristics of Faculty
Paul Jolly, Ph.D.

Volunteer Clinical Faculty: The Hope of the Future?
Jeremiah A. Barondess, M.D.

The Academic Careers of Physicians
Charles R. Sherman, Ph.D.

CAS Plenary Session
Presiding: Carmine D. Clemente, Ph.D.

October 27

Speaker: Jules Hirsch, M.D.
Presiding: Carmine D. Clemente, Ph.D.

Business Meeting
Presiding: Carmine D. Clemente, Ph.D.

COUNCIL OF DEANS

October 27

Business Meeting

Chairman: Stuart Bondurant, M.D.

COUNCIL OF TEACHING HOSPITALS

October 27

Business Meeting

Presiding: John W. Colloton

General Session

Presiding: Stuart J. Marylander

THE HIGH-COST PATIENT: IMPLICATIONS FOR PUBLIC POLICY AND THE TEACHING HOSPITAL
Marc J. Roberts, Ph.D.
Panel: Frank G. Moody, M.D.
Irvin G. Wilmot

GSA/MINORITY AFFAIRS SECTION

October 27

Regional Meetings:
Western
Northeast
Central
Southern

October 28

Business Meeting

AMERICAN INDIANS IN MEDICAL EDUCATION AND PRACTICE
Lois Steele, M.D.

DISCRIMINATORY PRACTICES IN PROFESSIONAL SCHOOLS, SPECIFICALLY LAW AND MEDICINE
Ralph Smith

MINORITY AFFAIRS PROGRAM

October 28

PRESENTATION OF NATIONAL MEDICAL FELLOWSHIP AWARDS
Leon Johnson, Ed.D.
Franklin C. McLean Award:
Keith L. Black
William and Charlotte Cadbury Merit Award:
Gregory Nanney

Keynote Speaker
TRENDS AND DEVELOPMENTS IN THE MINORITY APPLICANT POOL
A. Leon Higginbotham, Jr.

GSA-MAS SERVICE AWARD:
Clay E. Simpson, Jr., Ph.D.

MINORITIES IN MEDICINE—A CALL FOR ACTION IN THE SECOND DECADE
Maxine Bleich

ORGANIZATION OF STUDENT REPRESENTATIVES

October 24

DISCUSSION SESSIONS

Triumphs in Flexible Scheduling
Arlene Brown, M.D.
Mary Barton, M.D.
Lisa Capaldini
Dan Miller, M.D.
Ron Voorhees

October 25

Regional Meetings:
Northeast
Central
Western
Southern

Curricular Reforms vis-a-vis the "New Biology"
Lisa Capaldini
Ludwig W. Eichna, M.D.
M. Roy Schwarz, M.D.
Richard Shoemaker

Business Meeting

Regional Meeting:
Northeast
Central
Southern
Western

October 26

DISCUSSION SESSIONS

The NRMP and the Residency Selection Process
John S. Graettinger, M.D.

Lessons for U.S. Health Care from Other Countries:
Sweden, Great Britain and China
Claudia Morrissey
Neal Nathan, M.D.
Victor W. Sidel, M.D.

Marching Over, Under, Around and Through the Medical School Curriculum
Gordon H. Deckert, M.D.

Candidate for OSR Office Session

Business Meeting

Regional Meetings:
Western
Southern
Northeast
Central

WOMEN IN MEDICINE

October 26

CAREER DEVELOPMENT WORKSHOP: WRITING FOR PROFESSIONAL JOURNALS

Medicant: A Second Language?
Lois DeBakey, Ph.D.

Role of Publication in Academic Careers
James T. Hamlin, III, M.D.

Literature Search and Bibliography
Phyllis Mirsky

The Scientific Manuscript: Think First, Write Later
Lois DeBakey, Ph.D.

Clarity of Presentation
Evelyn Myers

Review Process
Merrill T. McCord

Ask the Editor
Arnold Relman, M.D.

Summation
Lois DeBakey, Ph.D.

GENERAL SESSION: THE TWO-CAREER FAMILY

Moderator: Grace Boxer, M.D.

Dual Career Couples: Situational Conflicts and Personal Coping
Barbara Strudler Wallston, Ph.D.

Personal Experiences
N. Lynn Eckhert, M.D., and Louis E. Fazen, III, M.D.
Maria Mack, M.D., and Dennis Mack

October 27

Regional Breakfast Meetings
Central
Western
Northeast
Southern

RESEARCH SYMPOSIUM

MALE AND FEMALE MEDICAL STUDENTS: THEIR PERSONALITIES, ACHIEVEMENTS AND PERCEPTIONS

Moderator: Roberta A. Monson, M.D.

Personality Characteristics of Entering Women Medical Students Over a Ten-Year Period
Patricia Blakeney, Ph.D.

A Longitudinal Study of the Achievement of Men and Women in Medical School
Louise Arnold, Ph.D.

Peer Expectations About Competencies of Men and Women Medical Students
Linda Grant

A Comparison of Male and Female Students' Academic Performance, Specialty Choice and Competitiveness of Post-Graduate Training Sites
Donna H. Harward

WHAT ARE THE TRUTHS ABOUT DISCRIMINATION?

Sex Discrimination in Medical School
Miriam Rosenthal, M.D.

Attitudes in the Medical Academic Community Toward Women Physician Leaders
Arlene Scadron, Ph.D.

October 28

A TALE OF O

A special presentation of *A Tale of O*, a slide-tape show based on Dr. Rosabeth Moss Kanter's research for her award-winning book, *Men and Women of the Corporation.* The slide-tape demonstrates what happens to any minority individual in a work group.

WOMEN DEPARTMENT CHAIRPERSONS MEETING
Moderator: Barbara Way, M.D.

COMPUTERS IN MEDICAL EDUCATION

October 27

COMPUTER-BASED INSTRUCTION IN MEDICAL EDUCATION
Moderator: G. Edward Lessard, Ph.D.
Panel: Ronald C. Comer

Lois Crandell
Tom Held
Martin Kamp, M.D.
Harvey Long
Steve Peach

October 29

ADMINISTRATIVE USERS OF COMPUTERS IN MEDICAL EDUCATION

Moderator: Marion J. Ball, Ed.D.
Panel: Beth Dawson, Ph.D.
Jane Elchlepp, M.D.
C. W. Goldsmith, Ph.D.
John F. Kasonic
Terrance M. Leigh, Ph.D.
Jack Lein, M.D.
Pat Lind
Michael G. McShane, Ph.D.

GROUP ON BUSINESS AFFAIRS

October 28

Regional Meetings
Northeast
Southern
Midwest
Western

October 29

DEVELOPING NEW HEALTH MANPOWER LEGISLATION— PERSPECTIVES OF THE CONGRESS, THE ADMINISTRATION, AND THE MEDICAL SCHOOLS

Moderator: Thomas J. Kennedy, Jr., M.D.
Participants: Brian Biles, M.D.
Karen S. Davis, Ph.D.
Robert F. Knouss, M.D.
Edward J. Stemmler, M.D.

CARROLL MEMORIAL LECTURE

Julius R. Krevans, M.D.

Business Meeting

IMPLEMENTING A-21—THE GBA A-21 COMPLIANCE COMMITTEE MEETS WITH HENRY KIRSCHENMANN OF DHHS

CHANGING THE STRUCTURE OF A MEDICAL PRACTICE PLAN: FIVE RECENT EXPERIENCES

MANAGING IN THE 80s—THE NEW REQUIREMENTS

Leland R. Kaiser, Ph.D.

GROUP ON INSTITUTIONAL PLANNING

October 25

Regional Meetings
Northeast
Midwest
Southern
Western

Business Meeting

October 26

National Program

DILEMMAS POSED BY THE NEW BIOLOGY FOR THE FUTURE OF MEDICAL EDUCATION

Moderator: J. Stephen Smith, Ph.D.

Keynote: David R. Challoner, M.D.

Speakers: Thomas A. Bartlett, Ph.D.
Gilbert S. Omenn, M.D.

GROUP ON MEDICAL EDUCATION

October 27

SPECIAL SESSIONS

Educational Development and Graduate Medical Education

Developed in conjunction with the Council of Residency Education in Ob/Gyn, the Association of Program Directors of Internal Medicine, and the Society of Teachers of Family Medicine

Moderator: Gary M. Arsham, M.D., Ph.D.

Panel: William E. Easterling, Jr., M.D.
Fitzhugh Mayo, M.D.
William L. Morgan, Jr., M.D.

A Spectrum of Programs in the Curriculum of the Clinical Years

Moderator: George L. Baker, M.D.
Panel: Judith Frank, M.D.
Howard Levitin, M.D.
Theodore Phillips, M.D.

Faculty Development: The Interface Between Assessment, Improvement and Promotion of Teaching Excellence

Moderator: David Irby, Ph.D.

Panel: Clinical Consultation Model
Leonard E. Heller, Ed.D.
A Collaborative Research Model
Frank T. Stritter, Ph.D.
A Departmental Peer Review Model
Albert Gordon, Ph.D.
A Corporate Faculty Model
John C. Sibley, M.D.

Discussant: Robert Rippey, Ph.D.

CLINICAL EVALUATION PROJECT—SPECIAL SESSION

Formal and Informal Evaluation Systems Within Clinical Departments

Discussion Leader: Xenia Tonesk, Ph.D.

Similarities and Differences in the Evaluation of Third-Year Clerks, Fourth-Year Clerks, Lower-Level Residents, and Upper-Level Residents

Discussion Leader: Xenia Tonesk, Ph.D.

GSA/MAS/GME Reception

October 28

INNOVATIONS IN MEDICAL EDUCATION EXHIBITS

INNOVATIONS IN MEDICAL EDUCATION DISCUSSION GROUPS

Instructional Design and Evaluation of Basic Science Courses
Moderators: Harold G. Levine and Ellen Feinstein

Instructional Design and Evaluation of Clinical Clerkships
Moderator: Paula L. Stillman, M.D.

Instructional Design and Evaluation of Residency Programs
Moderator: Fredric D. Burg, M.D.

Instructional Design and Evaluation of Continuing Medical Education Programs
Moderator: Leslie Sandlow, M.D.

Media and Biomedical Communications
Moderator: Malcolm Skolnick, Ph.D.

Interdisciplinary Health Education
Moderator: Peter Tuteur, M.D.

Faculty Development
Moderator: Hilliard Jason, M.D.

Educational Support Systems for Students, Including Tutoring and Remediation
Moderator: Marilyn Heins, M.D.

October 30

PLENARY SESSION

Education of the 21st Century Physician: The Immediate Challenge

Moderator: Frank T. Stritter, Ph.D.

Participants and Perspectives:

Practices of Clinical Medicine
Mary E. Avery, M.D.

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

Information Processing
Harold M. Schoolman, M.D.

National Pressures
Robert Knouss, M.D.

Institutional Charge
Victor Neufeld, M.D.

NATIONAL MEETING

A Proposal for the Study of the General Education of the Physician

Special Report
August G. Swanson, M.D.

Discussants: L. Thompson Bowles, M.D.
W. Loren Williams, Jr., Ph.D.

Regional Meetings
Western
Central
Southern
Northeast

SMALL GROUP DISCUSSIONS

INTERNAL ASSESSMENT OF THE EFFECTIVENESS OF EDUCATIONAL PROGRAMS IN GRADUATE MEDICAL EDUCATION

Moderator: Fredric D. Burg, M.D.
Panel: Gregory Carroll, PhD.
Victor C. Vaughan, M.D.
George Webster, M.D.

INTEGRATING FAMILY MEDICINE PROGRAMS INTO THE PREDOCTORAL MEDICAL CURRICULUM
Moderator: Paul Werner, M.D.
Panel: Roy Gerard, M.D.

Thomas Leaman, M.D.
D. Dax Taylor, M.D.

FOSTERING THE DESIRE TO CONTINUE LEARNING
Moderator: Gregory L. Trzebiatowski, Ph.D.
Panel: Daniel S. Fleisher, M.D.
Richardson K. Noback, Ph.D.
Barbara Sharf, Ph.D.

INSTITUTIONALLY BASED STUDENT DATA BANKS
Moderator: Charles Friedman, Ph.D.
Panel: David Anderson, Ph.D.
Larry Sachs, Ph.D.
Christel Woodward, Ph.D.

BASIC SCIENCE TEACHING REVISITED
Moderator: Robert Barker, Ph.D.
Panel: Sam L. Clark, Jr., M.D.
Parker Small, M.D.

FOURTH-YEAR CLERKSHIPS: ELECTED OR ALLOTTED
Moderator: Howard L. Stone, Ph.D.
Panel: Robert S. Meier, Ph.D.
Edward S. Petersen, M.D.

EVALUATION OF NON-COGNITIVE ABILITIES IN MEDICAL EDUCATION
Facilitator: Gordon H. Deckert, M.D.

CME MARKETING STRATEGIES WHICH BUILD ATTENDANCE
Moderator: George B. Vaughan, Ph.D.
Panel: Steven Goldfinger, M.D.
Braha Marcus-Ofseyer
Thomas C. Meyers, M.D.

INSTRUCTION IN ETHICS AND HUMAN VALUES
Moderator: E. A. Vastyan, B.D.
Panel: Warren T. Reich, S.T.D.
Joanne Trautmann, Ph.D.

CRITERIA FOR GRADUATING FROM MEDICAL SCHOOL
Moderator: T. Joseph Sheehan, Ph.D.
Panel: Louise Arnold, Ph.D.
James Davis, M.D.
Anthony E. Voytovich, M.D.

HOW CAN MEDICAL STUDENTS BE ATTRACTED TO ACADEMIC AND RESEARCH CAREERS?
Moderator: Thomas E. Morgan, M.D.
Panel: Robert B. Taylor, Ph.D.
Judith A. Ramaley, Ph.D.
Erich Hirschberg, Ph.D.

ATTRIBUTES OF QUALITY MEDIATED INSTRUCTIONAL MATERIALS
Moderator: James L. Bradford, Ph.D.
Panel: C. Michael Brooks, Ed.D.
William G. Cooper, Ph.D.
Antol Herskowitz
Linda W. Kudick
Robert E. Potts, Ph.D.

GME/NATIONAL FUND FOR MEDICAL EDUCATION

October 29

NEW PRIORITIES FOR RESEARCH IN MEDICAL EDUCATION
Speaker: John G. Freymann, M.D.

October 30

NEW PRIORITIES FOR RESEARCH IN MEDICAL EDUCATION
Discussants: John G. Freymann, M.D.
Robert D. Stone, Ph.D.

GME/SOCIETY OF MEDICAL COLLEGE DIRECTORS OF CONTINUING MEDICAL EDUCATION

October 27

LCCME ACCREDITATION GUIDELINES: Medical Schools
Moderator: David M. E. Allan, M.D.

LCCME ACCREDITATION GUIDELINES: Teaching Hospitals
Moderator: Norman S. Stearns, M.D.

LCCME ACCREDITATION GUIDELINES: Specialty Societies
Moderator: Joseph E. Johnson, III, M.D.

GROUP ON PUBLIC RELATIONS

October 27

Welcome Breakfast

Moderator: Carolyn Tinker

Speaker: John J. Cassidy

MEDICAL ETHICS IN THE 80s: THE PERSPECTIVES OF THREE PROFESSIONS
Moderator: Kay Rodriguez
Panel: Gordon Avery, M.D.

Alexander Capron
Donald Drake
Gina Bari Kolata

SCIENCE REPORTING IN THE 80S

Moderator: Richard Ridgway
Panel: Jules Bergman
Charles Crawford

ALUMNI MANAGEMENT AND PROGRAMMING AIDS FOR THE 80S

Time Management for the Alumni Professional
Moderator: Dorothy Dilorio
Speaker: Charles E. Kozoll

ROUND TABLE DISCUSSIONS

Basics of Organizing and Planning an Alumni Association Office

Discussion leaders: Milli Fox
Helen Sims

Are We Effective and How Do We Know?

Discussion leaders: Billie Clary
Linda Johnson

Student Programming—Communicating with and Cultivating Our Future Alumni
Discussion Leaders: Nancy Groseclose
Robert Keesecker

Teaching Hospital and Residency Program—Organizing, Activities, Who Gets Funding; How Incorporated into Alumni Structure
Discussion Leaders: Dorothy Estes

The Best System To Help You—Approaches to Servicing Alumni and Records Keeping and How You Use Information They Provide
Discussion Leader: Michael McShane, Ph.D.

Programs that Work: Reunions, Awards, Tours, Banquets, Receptions, Continuing Education
Discussion Leaders: Claire MacConnell
Cora Olgyay

How Do We Work Together—Relationship of Alumni Office with University, Deans, Department Heads, Hospital
Discussion Leaders: Perry Culver, M.D.
Katherine Walker

GPR Business Meeting

October 28

AWARDS PRESENTATIONS

Presiding: Kathryn Costello

Nominee Presentations for Excellence In:
Electronics Program-Audio
Joanne Brugger
Irene Haske

Electronics Program—Visual
Harold Kranz, Jr.
Stephen Stuyck
Publications
Andrew W.M. Beierle
Thomas P. Gore

Special Public Relations Project
Owen McNamara
Frank Weaver and Diana Stevens

Total Public Relations Program—Affiliated Teaching Hospital
Suzanne Stewart

AWARDS RECEPTION

AWARDS BANQUET

Presiding: Jack Righeimer
Speakers: Terry Barton
Philip Thorek, M.D.

Presentation of Awards: Julius R. Krevans, M.D.

October 29

Development Officers' Breakfast

THE BUILDING BLOCKS OF EFFECTIVE MEDICAL INSTITUTION ADVANCEMENT

Moderator: Robert Pierpont

Strategic Planning in the Academic Medical Center
Samuel Davis

Articulating the Case for Development
William Hobbie
Jan Krukowski

Development Lunch with Discussion Tables

THE INSTITUTION'S DEVELOPMENT TEAM: ADMINISTRATION, TRUSTEES, FACULTY, ALUMNI AND DEVELOPMENT OFFICERS WORKING TOGETHER

Moderator: David W. Canfield
Panel: William G. Anlyan, M.D.
Frank Bachich
Robert Buchanan, M.D.
Frances French
Sheldon Garber

Joseph D. B. King, M.D.
Thaddeus Lindner

GROUP ON STUDENT AFFAIRS PROGRAM

October 27

FINANCIAL AID FORUM

Thomas Butts
Robert Knouss, M.D.
Clifford Allen
Thomas R. Wolanin, Ph.D.

October 29

THE NUMBERS GAME: WHAT'S AHEAD FOR MEDICAL SCHOOL ADMISSIONS IN THE 80s

Moderator: Robert I. Keimowitz, M.D.

Overview
W. Albert Sullivan, M.D.

The Diminishing Applicant Syndrome: A State Perspective
Norma E. Wagoner, Ph.D.

Needs & Resources versus Opportunity: A Dilemma in Reducing Class Size
Thomas M. Johnson, M.D.

DISCUSSION GROUPS

Admission & Retention of Minority Group Students
Anna C. Epps, Ph.D.

Career Decisions of Medical Students
David M. Tormey, M.D.

The Impaired Student
Jane Thomas, Ph.D.

The Transfer Process & the Medical Sciences Knowledge Profile Examination
Andrew M. Goldner, Ph.D.

RESEARCH IN MEDICAL EDUCATION NINETEENTH ANNUAL CONFERENCE

October 29

PRESENTATION OF SYMPOSIA

EXPLICIT DEFINITIONS OF COMPETENCE FOR GRADUATE MEDICAL EDUCATION: WHAT, HOW AND SO WHAT?

Chairman: Philip G. Bashook, Ed.D.
Participants: Jerry D. Gates, Ph.D.
John S. Lloyd, Ph.D.
Discussants: Fredric D. Burg, M.D.
Leslie J. Sandlow, M.D.

COST AWARENESS EDUCATION AND PRACTICE OF MEDICINE: SOME NATIONAL AND INTERNATIONAL PERSPECTIVES

Chairman: Jack L. Mulligan, M.D.
Organizer: Mohan L. Garg, Sc.D.
Participants: Mohan L. Garg, Sc.D.
W. A. Gliebe
W. M. Kleinberg, M.D.
Evert Reerink, M.D., Ph.D.
George A. Schlichte, Ph.D.
Discussants: Mohan L. Garg, Sc.D.
Joseph Gonnella, M.D.
Howard S. Madigan, M.D.
William Sodeman, Sr.

EDUCATIONAL MODELS IN PRIMARY CARE

Chairman: Edward A. Wolfson, M.D.
Organizer: Lawrence P. Tremonti, M.D.
Participants: Craig Booher, M.D.
Daniel L. Moser
Robert H. Seller, M.D.
C. Kent Smith, M.D.
Discussants: W. Barry Biddle, Ph.D.
Lawrence P. Tremonti, M.D.

MEDICAL STUDENT EDUCATION FOR RURAL PRACTICE: INFLUENCE OF CURRICULUM AND LEARNING SITE

Chairman: Arthur Kaufman, M.D.
Participants: Tom Cullen, Ph.D.
Arthur Kaufman, M.D.
Paul T. Werner, M.D.
Discussant: Ronald Richards, Ph.D.

ALTERNATIVE APPROACHES TO RESEARCH ON CLINICAL REASONING

Chairman: Arthur S. Elstein, Ph.D.
Organizer: Michael M. Ravitch, Ph.D.
Participants: Georges S. Bordage, M.D.
Michael M. Ravitch, Ph.D.
David B. Swanson, Ph.D.
Discussant: Barbara McNeil, M.D., Ph.D.

PERSPECTIVES ON THE ROLES OF OFFICES OF MEDICAL EDUCATION IN THE 1980s

Chairman: Emil Petrusa, Ph.D.
Rose Yunker, Ph.D.
Participants: Stephen Abrahamson, Ph.D.
Charles Dohner, Ph.D.
Harold G. Levine

Frank Schimpfhauser, Ph.D.
T. Joseph Sheehan, Ph.D.

A MULTI-INSTITUTIONAL RESEARCH STUDY ON THE USE OF SIMULATION FOR TEACHING AND EVALUATING PATIENT EXAMINATION SKILLS

Chairman: Abdul W. Sajid, Ed.D.
Participants: Gordon A. Ewy, M.D.
Joel M. Felner, M.D.
Alan D. Forker, M.D.
Michael S. Gordon, M.D.
Dorthea Juul
Joan W. Mayer, M.D.
Abdul W. Sajid, Ed.D.
Robert A. Waugh, M.D.
Discussants: Howard S. Barrows, M.D.
Arthur S. Elstein, Ph.D.

RECRUITMENT AND SELECTION OF PHYSICIANS FOR PRIMARY CARE AND RURAL PRACTICE—RESULTS FROM THE PROJECT TALENT LONGITUDINAL STUDY

Chairman: Sandra R. Wilson, Ph.D.
Participants: Frances B. Stancavage
Sandra R. Wilson, Ph.D.
Lauress L. Wise, II, Ph.D.
Discussants: Paul Elliot, Ph.D.
Lee Sechrest, Ph.D.

LEARNING DURING THE SENIOR CLERKSHIP

Chairman: Hugh M. Scott, M.D.
Participants: Vimla Patel
Hugh M. Scott, M.D.
R. Kennedy Smiley, M.D.
Discussant: W. Dale Dauphinee, M.D.

MEDICAL SCHOOL LEARNING ENVIRONMENT: PROSPECTS FOR NEW RESEARCH DIRECTIONS

Chairman: Arthur Rothman, Ph.D.
Organizer: Sarah M. Dinham, Ph.D.
Participants: Sarah M. Dinham, Ph.D.
T. Joseph Sheehan, Ph.D.
Christel A. Woodward, Ph.D.
Critic: Edwin B. Hutchins, Ph.D.

THE "STANDARDS" DEVELOPED BY THE JOINT COMMITTEE ON STANDARDS FOR EDUCATIONAL EVALUATION: REFLECTIONS ON THEIR IMPACT FOR EVALUATION IN MEDICAL EDUCATION

Chairman: Hulda Grobman, Ed.D.
Participants: Phillip Bashook, Ed.D.
Hulda Grobman, Ed.D.
Vic Neufeld, M.D.
Discussant: Joseph S. Gonnella, M.D.

October 29

PRESENTATION OF PAPERS

STANDARDS AND STANDARD SETTING

Moderator: Bryce Templeton, M.D.
The Use of the Rasch Model to Test the Equivalence of Two Methods of Standard Setting
Peter H. Harasym, Ph.D.

A Comparison of Several Score Cutting Procedures and Their Effects on Success Rates
Ernest N. Skakun, et al.

Content Representativeness and Student Performance on National Board Part I Special Subject Examinations
William C. McGaghie, et al.

The Feasibility of Using a Canadian Examination for the Certification of Australasian Candidates in Psychiatry
Ernest N. Skakun, et al.

PREDICTING CAREER OUTCOMES
Moderator: Marcia Z. Wile, Ph.D.

The Role of Personal Themes in Medical Specialty Choice
Tod S. Sloan, et al.

Prediction of Medical Student Career Choice from a Freshman Personality Profile
Murray M. Kappelman, M.D., et al.

Proximate and Long-Term Effects of Early Exposure to Primary Care
Marian Osterweis, Ph.D., et al.

The Impact of Residency on Physician Practice Patterns: An Exploratory Analysis of Young Internists
Peter A. Weil, Ph.D., et al.

Physician Career Satisfaction: Another Look
Betty Hosmer Mawardi, Ph.D.

TEACHING CLINICAL SKILLS

Moderator: Edward Coppola, M.D.
Information Mapping in Introduction to Clinical Medicine
Emil Petrusa, Ph.D., et al.

Perceptions of Student-Patient Relations
Margaret E. Uguroglu, et al.

A Comparison of Structured and Self-Directed Approaches to Teaching Interviewing and Interpersonal Skills to Pediatric Residents
Leslie S. Jewett, Ed.D.

Teaching Medical Interviewing Skills: A Comparison of Medical and Non-Medical Tutors
Julian Bird, et al.

TEACHING IN THE CLINICAL SETTING

Moderator: John H. Littlefield, Ph.D.

Analysis of Clinical Experience—A Preliminary Report
Collin Baker, M.D.

Ideal and Actual Resident Teaching Practices in a University Hospital
Carter Zeleznik, Ph.D., et al.

Similarities of General Medicine Clinic in a Teaching Hospital to Internal Medicine Practice
Roberta A. Monson, M.D., et al.

The Relationship Between Medical Student Clerkship Activities and Performance on NBME Part II
Judith G. Calhoun, Ph.D., et al.

PLANNING CONTINUING MEDICAL EDUCATION

Moderator: Oscar A. Thorup, M.D.
The Educational Value of a Model Medical Care Evaluation Program
Leslie J. Sandlow, M.D., et al.

Characteristics Identified Upon Entrance to Medical School Associated With Future Participation in Professional Education
Linda K. Gunzburger, Ph.D.

Physicians' Practice Profiles: A Comparison of Sampling Methods
Lynn Curry, Ph.D.

Using Medical Audit Results to Plan Continuing Medical Education in Community Hospitals
Charles E. Osborne, Ed.D.

IMPACT OF RESIDENCY PROGRAMS: MEASUREMENT PERSPECTIVES

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

Faculty Perceptions of American and Foreign Pediatric Residents
T. Joseph Sheehan, Ph.D., et al.

Performance on Part III of the National Boards—The Effect of Residency Training
Jon Veloski, et al.

Patient Instructors as Evaluators of Housestaff Clinical Competence
Paul J. Rutala, M.D., et al.

ENHANCING STUDENT/FACULTY ENVIRONMENT INTERACTIONS

Moderator: Marilyn Heins, M.D.

Medical Student Needs: What and When
Grant D. Miller, M.D., et al.

Affective Learning in Medical Education
Elsbeth Kahn, Ph.D., et al.

Evaluation of a Medical School Learning Environment
A. Harris, Ph.D.

The Effects of Group Study Skills Counseling and Applied Relaxation on Study Behaviors and Test Anxiety in Medical and Dental Students
David G. Schroeder, Ph.D.

Development, Implementation and Evaluation of a Program to Improve Lecture and Presentation Skills
Donald S. Masler, M.D., et al.

EVALUATING CONTINUING MEDICAL EDUCATION

Moderator: Charles F. Johnson, M.D.

Investigations in CPR Training
David A. Gass, M.D., et al.

Efficacy of Traditional Continuing Medical Education in Changing Physician Knowledge and Behavior in the Care of Patients with Acute Myocardial Infarction
Carl W. White, M.D., et al.

A Model Continuing Educational Delivery System for Isolated Physicians in the Area of Pulmonary Medicine: Development and Evaluation
Muriel H. Bagshaw, M.D., et al.

Patient Care Appraisal in the Ambulatory Setting: Effectiveness as a Continuing Medical Education Tool
Wayne Putnam, M.D., et al.

CLINICAL PROBLEM SOLVING

Moderator: Geoff R. Norman, Ph.D.

Examination of the Effects of Structured Small Group Formats on Medical Students' Problem-Solving Performance
James M. Shumway, et al.

Clinically Relevant Problem Solving Evaluation in Preclinical Medical Education: A Study of Alternative Approaches
Sarah A. Sprafka, Ph.D., et al.

Problem Solving Analysis: A Piagetian Study
James P. Hale, Ph.D.

PREDICTABILITY OF PREDICTIVE TECHNIQUES

Moderator: Roger Girard, Ph.D.

Path Analysis of Medical Student Performance Data
Charles P. Friedman, Ph.D.

Canonical Redundancy Analysis: A New Technique to Predict Performance
Beth Dawson-Saunders, et al.

Incremental Validity: The Old and New MCATs Compared
Charles P. Friedman, Ph.D., et al.

The Relationship Between MCAT Subtest Scores and Performance in Medical School—The Impact of the Undergraduate Institution
Carter Zeleznik, Ph.D., et al.

Restriction of Range and the Predictive Validity of the New Medical College Admission Test
Thomas J. Cullen, Ph.D., et al.

DEVELOPMENT OF PATIENT ATTITUDES

Moderator: Miriam S. Willey, Ph.D.

Medical Students' Attitudes Towards Patients' Physical, Psychological and Health State Characteristics
C. Warner Johnson, M.D., et al.

Developing a Psychosocial Educational Program for Primary Care Physicians: Needs Assessment and Evaluation Baseline
Steven A. Cohen-Cole, M.D., et al.

Fostering Emotional Defensiveness in Intensive Care Unit Residents
Joel Frader, M.D., et al.

Minutes of AAMC Assembly Meeting

October 28, 1980

Washington Hilton Hotel, Washington, D.C.

Call to Order

Mr. Charles B. Womer, AAMC Chairman, called the meeting to order at 8:30 a.m.

Quorum Call

The Chairman recognized the presence of a quorum.

Consideration of Minutes

The minutes of the November 6, 1979, Assembly meeting were approved without change.

Report of the Chairman

Mr. Womer deferred presentation of remarks from the Chairman until the plenary session later that morning. (Copy of remarks attached to archive minutes.)

Report of the President

Dr. John A. D. Cooper reported that the five major medical education and professional groups, the AAMC, the American Medical Association, the Council on Medical Specialty Societies, the American Hospital Association, and the American Board of Medical Specialties, had entered into a new era of cooperative activity regarding accreditation of continuing medical education and graduate medical education. Two new accreditation organizations, the Accreditation Council for Continuing Medical Education and the Accreditation Council for Graduate Medical Education, were scheduled to begin operating January 1, 1981, replacing the Liaison Committee on Continuing Medical Education and the Council for Accreditation of Continuing Medical Education, and the Liaison Committee on Graduate Medical Education, respectively.

Dr. Cooper also reported on new projects at the Association. The Department of Teaching Hospitals and the Department of Health Services would be combined under Dr. Richard Knapp, as Dr. James Hudson was leaving the Association. This combined department would have responsibility for a new project funded by the Administration on Aging through which the Association would provide technical assistance in several areas to long-term gerontology centers. The Association also planned to begin a major study of the undergraduate medical education and premedical education years to complement recent studies on continuing and graduate medical education. It was anticipated that the report from the Association's case mix study for teaching hospitals would be available in 1981. Also, the Association would sponsor a second invitational conference for residents in January 1981.

Report of the Council of Deans

Dr. Stuart Bondurant reported that Dr. Cornelius Pings, chairman of the National Commission on Research, had spoken to the Council at its business meeting. Dr. Bondurant requested that Dr. William Deal's name be removed from the list of COD candidates for Distinguished Service Membership since his return to the deanship of the University of Florida College of Medicine disqualified him for this recognition.

Dr. Bondurant also asked that the Assembly consider a statement adopted by the Council of Deans in response to a decision by the Board of Regents of the University of the State of New York to accredit certain foreign medical schools.

Statement on Board of Regents Action

ACTION: *On motion, seconded, and carried, the Assembly agreed, by the necessary two-thirds vote, to consider the adoption of the statement of the*

Council of Deans with respect to the New York Board of Regents decision to accredit certain foreign medical schools.

Dr. Bondurant made a motion to adopt the following statement:

The Assembly believes that the policy adopted by the Board of Regents of the University of the State of New York to accredit certain foreign medical schools will be an inducement to many students to seek a less than adequate professional educational experience. The policy will inevitably degrade the quality of care available to the people of New York and potentially the nation.

The new accreditation policy will grant privileges in New York to students from foreign medical schools equivalent to those afforded medical students in the United States medical schools. The Assembly does not believe that the evaluation of foreign medical schools, proposed by the Board of Regents of the State of New York, could possibly be as effective as the national accreditation process. The Assembly supports the maintenance of a single national standard and system for evaluating and accrediting medical schools.

The process contemplated by the Board of Regents of the State of New York would be based on an evaluation of responses to a questionnaire and in some cases a site visit paid for by the institution being accredited. National accreditation decisions are based on a time-tested process involving an extensive review of observations and evaluations by a panel of experts.

All medical schools in the United States are organized as, or part of, nonprofit institutions. The Assembly believes that accreditation by the Board of Regents of the State of New York will be sought primarily by foreign for-profit schools dedicated to recruiting U. S. citizens as students, and that those granted accreditation will use the imprimatur of the Board of Regents of the State of New York to enhance their recruiting efforts

The Assembly believes that the policy is not in the public interest and that it ought to be reconsidered

ACTION: *On motion, seconded, and carried, the Assembly unanimously approved the motion.*

Report of the Council of Academic Societies

Dr. Carmine Clemente stated that the activities of the Council of Academic Societies had centered around its fall program and business meeting and the spring interim meeting. These forums were used to address issues in health manpower, stabilization, research grants support, essentials for research training programs, inter-specialty cooperation in graduate medical education, development of faculty for research careers, competitive marketing of medical services, and new faculty responsibilities and accountability for research activities. Senator Richard Schweiker had appeared as the keynote speaker at the spring meeting; Dr. Jules Hirsch addressed the fall meeting.

The American Association for the Surgery of Trauma and the Association of Departments of Family Medicine were proposed for membership.

Report of the Council of Teaching Hospitals

Mr. John Colloton announced that the Council of Teaching Hospitals had made progress during the year to modify Medicare routine service cost limits to include a new educational intensity adjustment to make the regulations somewhat more equitable and to eliminate a requirement that primary care training grants be fully offset against Medicare and Medicaid reimbursement. The Medicare regulations on intensive care units originally published in the *Federal Register* were modified to a more reasonable form. Mr. Colloton reported that the Council was still working to repeal or modify Section 227 relating to the teaching physician reimbursement issue and to make uniform hospital reporting and accounting acceptable.

Mr. Colloton called the attention of the Assembly to recent Association publications on teaching hospitals and the ongoing case mix study of 30 COTH hospitals. Finally, he emphasized that the effects of price competition and the trend toward multiple hospital systems, advocated by both the business community and the federal government, were issues of deep concern to the Association.

Report of the Secretary-Treasurer

In the report of the Secretary-Treasurer, Mr. Colloton reviewed the activities of the Audit Committee and the Association's financial statement.

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

Report of the Organization of Student Representatives

Dr. Daniel Miller reported that the Organization of Student Representatives had distributed an electives bulletin to all deans of student affairs, providing information on the policies and medical school contacts for clinical electives available to visiting medical students. The OSR handbook for student participation in LCME accreditation visits had been revised. The OSR had also completed a due process survey for presentation to the Group on Student Affairs. An *OSR Report* had been devoted to organizational strategies for resident selection, and the Northeast Pilot Project on Graduate Medical Training Information had resulted in the development of a model questionnaire for obtaining information from recent graduates on the quality and character of residency training programs.

The OSR annual meeting program had included sessions on curriculum and curriculum reform, sociobiology, and alternative health care systems. Approximately 20 resolutions were adopted at the business meeting and would be presented to the Chairman of the Council of Deans.

Grady Hughes, a third-year student of the University of Washington, Seattle, was named Chairperson-Elect of the OSR.

Election of New Members

ACTION: *On motion, seconded, and carried, the Assembly by unanimous ballot elected the following organizations, institutions, and individuals to the indicated classes of membership:*

Institutional: Uniformed Services University of the Health Sciences School of Medicine; University of Nevada School of Medical Sciences; and Wright State University School of Medicine.

Academic Society: American Association for the Surgery of Trauma and Association of Departments of Family Medicine.

Teaching Hospital: Allentown and Sacred Heart Hospital Center, Allentown, Pennsylvania; Moses H. Cone Memorial Hospital, Greensboro, North Carolina; Mount Carmel Mercy Hospital, Detroit, Michigan; University of Texas System Cancer Center, Houston, Texas; and Valley Medical Center of Fresno, Fresno, California.

Corresponding: Carle Foundation Hospital, Urbana, Illinois; Community Hospital of Indianapolis, Inc., Indianapolis, Indiana; National Jewish Hospital and Research Center–National Asthma Center, Denver, Colorado; Northridge Hospital Foundation, Northridge, California, Ohio Valley Medical Center, Wheeling, West Virginia; Santa Clara Valley Medical Center, Santa Clara, California; and Veterans Administration Medical Center, Salem, Virginia

Individual: (List attached to Archive Minutes.)

Distinguished Service: Theodore Cooper; Ronald W. Estabrook; Rolla B. Hill, Jr, and Frederick C. Robbins.

Emeritus: William B. Bean; Gerhard Hartman; and Hans Popper.

Change in AAMC Bylaws

ACTION: *On motion, seconded, and carried, the Assembly approved the following bylaw change:*

Article I, Section 1, Part A to read:

Institutional members shall be medical schools and colleges located within the United States and its territories.

Article II, Section 1, Part D to read:

Provisional Institutional members shall be newly developing medical schools and colleges located within the United States and its territories.

Report of the Resolutions Committee

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

Report of the Nominating Committee

Dr. Leo Henikoff, Chairman of the AAMC Nominating Committee, presented the report of the Nominating Committee. The Committee is charged by the bylaws with reporting to the Assembly one nominee for each officer and member of the Executive Council to be elected. The following slate of nominees was presented: Chairman-Elect: Thomas K. Oliver, M.D.; Executive Council, COD representatives: John W. Eckstein, M.D., Richard Janeway, M.D., Richard H. Moy, M.D., Edward J. Stemmler, M.D.; Executive Council, COTH representative: Mitchell T. Rabkin, M.D.; Executive Council, CAS representative: Virginia V. Weldon, M.D.; Distinguished Service Member: Manson Meads, M.D.

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

Presentation by Murray Grant, M.D.

Dr. Murray Grant, chief medical officer of the General Accounting Office, reported to the Assembly on a recent GAO study on the use of student assistance programs by U.S. citizens studying medicine abroad. A copy of Dr. Grant's remarks is attached to the archives minutes.

Installation of New Officers

Dr. Julius R. Krevans was installed as the AAMC's new Chairman at the Plenary Session immediately following the Assembly Meeting.

Adjournment

The Assembly adjourned at 9:40 a.m.

Annual Report

Message from the President

John A. D. Cooper, M.D., Ph.D.

This year's annual meeting of the Association focuses on the new biology and its impact on medicine and medical education. Recognition of the benefactions of science in the relief of suffering and the advancement of human happiness is timely and highly appropriate. We should pay formal tribute to the superb scientists, many from the faculties of our institutions, who created this modern intellectual revolution. Within a single generation, the conceptual framework of almost every preclinical and clinical science has been virtually restructured and fleshed out in extraordinarily rich detail. Medical progress has been breathtaking as the concepts and the measuring devices of science have been brought to bear on human disease, and as countless new preventive, diagnostic and therapeutic modalities have emerged. Not all problems have been solved, but the prevailing optimism is solidly grounded in reality.

However, despite the vigor and health of the scientific enterprise, we live in an era of strange and shifting assessments of priorities and of values. There are those who would neglect the contributions of science and dwell on perceived miscarriages of technology. These miscarriages are not the consequences of science, but of the technology that grows out of science. Science itself has the power to solve the problems, but technology now moves ahead so rapidly that adequate safeguards may not always be put into place. This disillusion with science is but a reflection of the larger criticism for the present forms of our culture.

Antipathy toward science is a comparatively recent phenomenon in the United States. In *The Home of Science* Dael Wolfle has described science in the nineteenth century as in a position of high esteem, viewed as helping man to "... understand the grand design and the purpose of the Creator of all things. If the new truths could be put to practical use, so much the better, but even if they never proved useful in a commercial sense, new truths were good in themselves." In that era, science was simpler, advances were more easily understood, and the subject was popular among educated Americans. Its contributions to the development of technology were rapidly assimilated in the industrial revolution.

Today science has become more complex and thus less understood by the average citizen. The very power of modern science brings fears that its mastery of nature may bring domination over man; that it is carried out by monstrous people in secret, dark places; that it is a sorcerer's apprentice whose excesses cannot be controlled; or that the andromeda strain will not be only the product of a fertile imagination. This concern has been sharpened by the specter of the destruction that is possible by the application of nuclear science to the engines of war; the same nuclear science that will provide us with controlled fusion energy that might make it possible for the people on an ever more crowded planet to live without destroying each other as a means of survival.

In medicine the concerns are directed at the cost of advances in the prevention, diagnosis and treatment of disease through biomedical research. Does it pay? What is the cost effectiveness? There are the keystones of the economic mensuration of technological advances growing out of scientific progress. Advocates of the economic approach have a difficult time with the calculus of their equations because it

requires the quantification of such variables as the value of life and the benefit of reducing human suffering and anxiety. Perhaps the concepts can be formalized in the sterile isolation of the computer room by proposing impersonal choices for an aggregate population. But their implementation requires application to individual human beings, a quite different matter and one that a physician is not prepared by training or by temperament to make.

This is not to say that we cannot husband our resources more effectively in medicine; that we should allow the art of medicine to be submerged in the tide of technological advances; that we cannot be more frugal in the use of laboratory tests and x-ray examinations; that we should not continuously examine our medical armamentarium and discard those things that cannot be demonstrated to be well grounded or efficacious. However, to withhold new techniques and new technology in medicine would be equivalent to forcing fiscal managers to abandon the computer and return to green eye-shaded bookkeepers, or Ma Bell to reincarnate the telephone operator and the magneto ringer.

The changing attitude toward science is reflected in the actions of Congress. It is quite different from the situation a half century ago when the Ransdell Act established a broad statutory base for the eleven Institutes that now constitute the National Institutes of Health. The legislation provided a continuing commitment for the federal support of research. It recognized that flexibility was critical to the most effective exploitation of research opportunities because of the variation in the rate of advance along the wide front of biomedical research. From this concept grew a partnership between the federal government and the biomedical science community that has resulted in incredible progress in our understanding of living systems and their alteration in disease. These advances have revolutionized medicine and placed it on an increasingly sounder scientific base.

Paralleling this remarkable increase in the ability of the medical profession to combat the scourges of disease, however, has been an increased difficulty of the Congress in contending with challenges arising from complicated social problems, and the limitations on the capabilities of science to give precise answers to profound questions which are only partially scientific in nature. With this circumstance exacerbated by the frequent turnover among both Houses of Congress, and especially among those individuals who comprise the staffs for both members and Congressional committees, the ability of the Congress to cope is sharply circumscribed. Although numerous suggestions have been made as to the most effective methods by which that body can gain essential and timely information so as to grapple successfully with issues which Alvin Weinberg described so appropriately as "trans-science" in character, no truly effective and acceptable solution to that problem has been found. As a consequence, the Congress is frequently in the position of enacting legislation without a full appreciation of the possible consequences on a scientific activity, especially when the characteristics of that activity are so markedly different from that of the political environment.

Today, attempts are being made to draw federal support of biomedical research further into the web of Congressional control. The permanent statutory authorities for the National Institutes of Health, which have protected programs from the vagaries attendant on reauthorizations every three years, would be replaced by a more tenuous commitment to the support of biomedical research and subject programs to a greater hazard of politicalization of the enterprise. The Congress has an undeniable right to enact restrictive legislation for NIH, just as it has a right to continue the permanent authorities that a long list of wise and distinguished legislators have felt the more appropriate statutory framework for federal engagement in the support of the "endless frontier" of biomedical research. However, there is no need for short-term authorizations and periodic renewals simply to monitor or to maintain control over research agencies. Congress can exercise its responsibility for monitoring the expenditure of public funds and assuring the accountability of the NIH through oversight and appropriations hearings. There is no convincing evidence that legislation altering the status of the National Cancer Institute or the National Heart, Lung, and Blood Institute has benefited

their programs or accelerated the understanding or amelioration of the diseases to which they are dedicated.

The controllable federal programs for the support of biomedical research have greater difficulty in competing with the demands of uncontrollable service programs in a period of restricted resources. In this situation, policymakers must recognize the unique nature of biomedical research, the key role that investigators must have in identifying the most fruitful areas to promote at any given time on the rapidly changing front of new knowledge. Scientists must become more concerned with the integrity of federal programs and the overall strength of the institutions in which they work and less with their own narrow areas of interest. Unless we have statesmen in both the public and private sectors, we risk losing one of the medical miracles of the twentieth century and the envy of the world.

Executive Council, 1979-80

Charles B. Womer, chairman
Julius R. Krevans, chairman-elect
John A. D. Cooper, president

Council Representatives:

COUNCIL OF ACADEMIC SOCIETIES

David M. Brown
Carmine D. Clemente
Daniel X. Freedman
Thomas K. Oliver, Jr.

DISTINGUISHED SERVICE MEMBER

Robert J. Glaser

COUNCIL OF DEANS

Steven C. Beering
Stuart Bondurant
John E. Chapman
Theodore Cooper
Neal L. Gault, Jr.
Richard Janeway
William H. Luginbuhl
Allen W. Mathies, Jr.
Leonard M. Napolitano

COUNCIL OF TEACHING HOSPITALS

John W. Colloton
Robert M. Heyssel
Stuart J. Marylander
John Reinertsen

ORGANIZATION OF STUDENT REPRESENTATIVES

Lisa Capaldini
Dan Miller

Administrative Boards of the Councils, 1979-80

COUNCIL OF ACADEMIC SOCIETIES

Carmine D. Clemente, chairman
Daniel X. Freedman, chairman-elect
F. Marian Bishop
David M. Brown
Lowell M. Greenbaum
Robert L. Hill
T. R. Johns
Joseph E. Johnson
Thomas K. Oliver, Jr.
James B. Preston
Virginia V. Weldon
Frank C. Wilson

COUNCIL OF DEANS

Stuart Bondurant, chairman
Steven C. Beering, chairman-elect
Theodore Cooper
John E. Chapman
Neal L. Gault, Jr.
Richard Janeway
William H. Luginbuhl
Allen W. Mathies, Jr.
Richard H. Moy
Leonard M. Napolitano

COUNCIL OF TEACHING HOSPITALS

John W. Colloton, chairman
Stuart J. Marylander, chairman-elect
Dennis R. Barry
James Bartlett
Fred J. Cowell
Robert E. Frank
Earl J. Frederick
Robert M. Heyssel
Mark S. Levitan
Robert K. Match
Mitchell T. Rabkin
Malcom Randall
John Reinertsen
Elliott C. Roberts

ORGANIZATION OF STUDENT REPRESENTATIVES

Dan Miller, chairperson
Lisa Capaldini, chairperson-elect
Mary Barton
Arlene Brown
Susan Haack
Doug Hieronymous
Greg Melcher
Claudia Morrissey
Stephen Sheppard
Peter Shields
M. Louis Van de Beek

The Councils

Executive Council

Between annual meetings of the Association, the quarterly Executive Council meetings provide the chief forum for consideration of policy matters relating to medical education. Issues are brought to the Council's attention by member institutions or organizations or from one of the constituent Councils. Policy matters considered by the Executive Council are first referred to the Administrative Boards of the constituent Councils for discussion and recommendation before final action.

The traditional December retreat for the Association's officers and executive staff provided an intensive background briefing for many issues which the Executive Council would consider throughout the year. Preliminary discussions were held on appropriate Association positions on national health insurance, health manpower legislation, the number of clinical investigators, the report of the Graduate Medical Education National Advisory Committee, and pending legislation on issues relating to federal research activities. An annual assessment of the Association's involvement with other organizations included a review of the activities of the Coordinating Council on Medical Education and the Liaison Committees, developing relations with the Federation of State Medical Boards, and improved coordination with the Association of Academic Health Centers. The participants also defined new Association initiatives to increase house staff participation, to improve monitoring of state legislative developments, to increase educational efforts on indirect costs and to initiate a project on medical school curricula. Strategies to implement the recommendations of the Task Force on Graduate Medical Education were considered. A briefing on the New York test disclosure law and the Association's efforts to obtain judicial relief was included on the retreat agenda.

Throughout the year the Executive Council actively reviewed the Association's participation in the Coordinating Council on Medical Education and the developing Council for Medical Affairs designed to supersede the CCME. The Council approved several changes to strengthen the Liaison Committee on Graduate Medical Education, including a new plan for financing accreditation activities, restructuring of LCGME membership, and recommendations for certain standing committees. Work continued to resolve differences among LCGME parent organizations on the general requirements section of "The Essentials of Accredited Residencies in Graduate Medical Education." The Executive Council followed with interest the continuation of the Liaison Committee on Continuing Medical Education after the American Medical Association withdrawal. It strongly supported the LCCME and urged that every effort be undertaken to reconcile apparently divergent views and to reestablish a single agency for continuing medical education accreditation.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees and task forces, including new ad hoc committees on External Evaluation Review and Competition, chaired respectively by Carmine Clemente and Robert Tranquada. The External Evaluation Review Committee has been charged with studying a number of existing and proposed examinations of medical knowledge including the National Board of Medical Examiners tests, the Comprehensive Qualifying Examination, the Federation Licensing Examination, and the Medical Sciences Knowledge Profile. Consideration by the Council of new Congressional initiatives to increase marketplace competition in the health sector revealed serious concerns about the impact of such proposals on medical schools and teaching hospitals. The Competition Commit-

tee will suggest options for the Association in this area.

The final report of the ad hoc Committee on Clinical Research Training, containing recommendations for action by the Association, medical schools, the federal government, and the private sector, was adopted. An implementation plan for the report of the Task Force on Minority Student Opportunities in Medicine was also approved. The Council monitored the ongoing work of the ad hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals. Final action to approve a position paper on "The Expansion and Improvement of Health Insurance in the United States" occurred in June.

The Task Force on Graduate Medical Education, under the leadership of Jack Myers, submitted a final report incorporating chapters from each of its five working groups. The report was accepted for wide distribution and the Executive Council proposed that the report be used as a working document for an invitational conference on graduate medical education in September 1980.

As Chairman of the Task Force on the Support of Medical Education Edward Stemmler met with the Executive Council to crystallize Association response to pending manpower legislation, and then communicated the Association's views in a series of appearances before Congressional committees. Manpower legislative proposals prompted Executive Council discussion and positions on several related issues, including institutional support, student assistance, reimbursement for primary care residents, foreign medical graduates, and extension of health manpower program benefits to chiropractic.

Also in the manpower area, the Association made a written response to the preliminary report of the Graduate Medical Education National Advisory Committee. That committee had been established in 1977 to advise the federal government about physician manpower needs, physician specialty distribution, and federal graduate medical education policies. The preliminary report, released in the summer of 1979, consisted principally of statistical data and an overview of GMENAC's plans for estimating the numbers of various specialists needed in the 1990s.

Another area of legislative activity requiring substantial attention from the Executive Council involved Senate and House proposals to extend authorities for certain NIH institutes and to make other changes in the federal research endeavor. The Council strongly opposed time-limited authorizations and appropriation ceilings for the NIH institutes and recommended other modifications concerning peer review for intramural research and contracts and the development of annual research plans. The Executive Council also responded to Administration efforts to stabilize research support through an annual funding of approximately 5,000 competing research project grants by cautioning that such stabilization should not be accomplished at the expense of other vital NIH programs.

The Council's interest in reimbursement issues continued with a review of proposed policies for Medicare reimbursement for pathology services. An Association position endorsing reimbursement based on a relative value scale as one option of compensation for pathology was adopted.

Misunderstanding at both the institutional and federal level concerning the nature and role of indirect costs troubled the Council and it considered several strategies through which the Association could disseminate better information on this issue.

Acting on a recommendation from the officers' retreat to encourage greater participation from house staff in Association activities, the Executive Council authorized a second invitational conference for residents. Scheduled for January 1981, the conference will deal with resident responsibilities in evaluation.

Proposed changes in the National Board of Medical Examiners and in the tests provided by that organization prompted discussion within the Executive Council and led to a request for closer staff involvement with the NBME and a study of the proposed Comprehensive Qualifying Examination.

Seymour Perry, Director, National Center for Health Care Technology, addressed a joint meeting of the Administrative Boards in June to describe that office's function. A lively question and answer session revealed concerns about the prospects of medical technology review by a federal agency. Other joint Board

sessions were devoted to a review and critique of "The Organization and Governance of Academic Health Centers," a report of the Association of Academic Health Centers and the reports of the National Commission on Research.

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

The Executive Council, along with the Secretary-Treasurer, Executive Committee and Audit Committee, exercised careful scrutiny over the Association's fiscal affairs, and approved a modest expansion in the general funds budget for fiscal year 1981.

The Executive Committee met prior to each Executive Council meeting and conducted business by conference call as necessary. The Executive Committee met in June with the Executive Committee of the American Medical Association to initiate a series of meetings to effect a closer working relationship between the two organizations. The Executive Committee also held a joint meeting with the Association of Academic Health Centers to increase coordination and cooperation between the AAMC and the AAHC.

Council of Deans

Two major meetings dominated the Council of Deans calendar in 1979–80 with the business meeting conducted at the Association's annual meeting in Washington, D.C. and the Council's spring meeting in Ft. Lauderdale, Florida. Additionally, the Administrative Board met quarterly to deliberate Executive Council items of significant interest to the full membership. More specific concerns were addressed by smaller groups of deans brought together by common interests.

The primary discussion at the annual business meeting centered on the progress reports of the Association's task forces and committees, including the task force on the support of health manpower, and the *ad hoc* committees on continuing medical education and clinical research training. A panel consisting of Theodore Cooper, Richard Ross, and Daniel Tosteson discussed the merits of S.988, the Health Science Promotion Act of 1979. Despite the desire of the bill's authors to advance the interests of the NIH and of biomedical research, a number of the bill's provisions were troubling to the Council. The recently drafted Universal Application Form for Graduate Medical Education was critiqued by the Council. A draft position paper on the expansion and improvement of health insurance in the United States was the subject of substantial deliberation; a number of suggestions were offered for refining the document. Following the formal business meeting, Albert P. Williams, Senior Economist at the Rand Corporation, presented a report tracing the progressive diffusion of board certified specialists into non-urban areas.

Ninety-seven deans attended the April 9–12 Council of Deans Spring Meeting, devoted to "Preparing the Physician of the Future." Jeremiah A. Barondess, President of the American College of Physicians, presented his views on the expectations and curricular needs of the future physician and Rudolph H. Weingartner, Dean of the College of Arts and Sciences at Northwestern University, and Thomas H. Meikle, Assistant to the President of The Macy Foundation, discussed the undergraduate academic preparation of candidates for medicine. Scientific and technological advances were described in a presentation by David M. Kipnis, Chairman of the Department of Medicine at Washington University, on the new biology and its implications for the future of medical education. The deans witnessed a remarkable demonstration by Jack Myers, University Professor of Medicine at the University of Pittsburgh, of medical applications of computer technology: the Internist program for computer consultation in the diagnosis of diseases in the field of internal medicine. In addition, Ludwig Eichna, former chairman of the Department of Medicine at SUNY-Downstate, presented a student's perspective of medical education from 1975–79 while Charles Fried, Professor of Law at Harvard University, provided an extra-scientific perspective on medical education. The presentations and demonstration stimulated much discussion among the deans regarding changes which might be appropriate in admissions and educational policy.

During the spring business meeting, the

Council discussed prospective health manpower legislation; proposals for the stabilization of research grant support; the report of the AAMC clinical research committee; the development and current status of both the Liaison Committee on Graduate Medical Education and the Liaison Committee on Continuing Medical Education; proposed changes in the governance of the National Board of Medical Examiners as well as the implementation of the comprehensive qualifying exam and its relationship to the proposed Federation Licensing Examination I (FLEX I); a proposal for a study of the general professional education of the physician; and the AAMC invitational meeting on the Graduate Medical Education Task Force Report. The deans endorsed the AAMC statement on "The Expansion and Improvement of Health Insurance in the United States." Two resolutions were adopted. One repudiated the concept, methodology, results, and reporting of the ranking of the nation's medical schools conducted by the magazine *Private Practice;* in the second the Council of Deans stated that academic policy and procedure were uniquely the province of each institution's internal governance process and did not recognize statements of "policy" on matters of institutional responsibility made by external organizations as binding on their institutions.

Of the many items considered by the COD Administrative Board, several deserve special note. These include endorsing the Task Force on Minority Student Opportunities in Medicine and establishing criteria for members of the New and Developing Community Based Medical School Section of the Council of Deans. The Board also received a description of the preliminary work by an ad hoc committee on the IRS definition of research.

Sections of the Council that met during the year were the Southern and Midwest deans, the deans of New and Developing Community Based Medical Schools and the deans of Private Freestanding Schools. The deans of new and developing schools attended a symposium on the development of a research program conducted in cooperation with the National Institutes of Health, the National Center for Health Services Research, the National Science Foundation, and the Health Services Administration.

Council of Academic Societies

The activities of the Council of Academic Societies during the year centered around the business meeting and program held in the fall at the AAMC Annual Meeting and the CAS Interim Meeting held in March. The Administrative Board of CAS conducted the business that arose throughout the year during quarterly meetings held in conjunction with the Executive Council meetings.

Membership in CAS now totals 69 academic societies. The increasingly important and visible role of CAS in representing the interests of U.S. medical school faculty was evidenced by the record high attendance at both the fall and spring meetings.

At the 1979 annual meeting, the CAS sponsored group discussions on five issues: clinical research manpower, research resource strategies, competency testing, accreditation of graduate medical education, and specialty distribution of physicians. Each of the groups formulated recommendations on these topics which were endorsed by the full Council and forwarded to the appropriate AAMC councils and committees. At the CAS fall meeting, Dr. Gerald Klerman, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, spoke to the Council about the ADAMHA programs and current issues in mental health of concern to academic medicine.

The CAS Interim Meeting also utilized group discussions, a format which has proved very popular since it provides a unique opportunity for national academic societies to discuss issues of importance to a wide variety of faculty. Topics addressed were health manpower, stabilization of research grant support, and essentials for research training programs. At the business meeting, Senator Richard Schweiker's keynote address stressed the importance of academic medicine's contributions to biomedical research, patient care, and education. Senator Schweiker urged medical school faculties to be more active in publicizing the accomplishments of our national research effort and to be more vocal about federal support of biomedical research and medical education.

The Association continued to sponsor the CAS Services Program for societies desiring special legislative tracking and office manage-

ment services from AAMC. Five societies participated in the program in 1979–80: Association of Professors of Medicine, American Academy of Neurology, Association of University Professors of Neurology, American Neurological Association, and the American Federation for Clinical Research. The AAMC also continued to publish the quarterly *CAS Brief* to inform medical school faculty about current issues and the periodic CAS Alerts to inform members about issues requiring immediate attention and action.

Council of Teaching Hospitals

The Council of Teaching Hospitals held three general membership meetings during 1979–80. On July 10, 1979, a COTH special membership meeting at Georgetown University Hospital allowed Health Care Financing Administration (HCFA) representatives to describe the agency's policies regarding Section 223 Medicare limitations and exception methodologies and provided a forum for COTH members to express their concerns regarding the regulation's adverse effects on teaching hospitals.

Leonard D. Schaeffer, then HCFA Administrator, discussed HCFA's program authority and its mission with regard to provider reimbursement. Schaeffer emphasized that "just paying the bills is not adequate in the current economic/scientific environment" because "the way we pay bills has an effect on the behavior" of both consumers and providers of care. However, he explained that HCFA's regulatory posture had "not really been a grand strategy" to limit hospital costs. Rather, it had grown from incremental policy changes devoted to resolution of individual problems. Schaeffer described the June 1979 Section 223 regulations as the product of a slow evolution since initial implementation of the routine service cost approach in 1974.

Robert O'Connor, Acting Director of HCFA's Bureau of Program Policy, provided an historical overview of the development of the Section 223 limitations. He believed that Congressional intent regarding Section 223 had been misinterpreted by hospitals and explained that HCFA's understanding was that "Congress wanted a statistical system that would set up presumptive limits on hospital costs" and require hospitals to justify costs exceeding these limits.

Discussing HCFA's activities in the development of the case mix/total costs reimbursement system, Clifton Gaus, then Director of HCFA's Office of Research, Demonstrations and Statistics, explained that the system would use the Yale DRG (diagnosis related groups) model to establish a relative case mix index for each hospital and calculate average costs per case at each institution.

The COTH session of the fall AAMC Annual Meeting, discussed the potential conflict between continuing advancements in medical technology and the quest for hospital cost containment. Speaking on "What's Ahead in the Medical Technology Explosion?", Barry Weinberg, President of Channing, Weinberg and Company, noted that new technologies continued to escalate and the demarcations between medical specialties were blurred by these new advances. In assessing upcoming technological developments, Mr. Weinberg emphasized noninvasive diagnostics, use of nutritional solutions in pre- and post-operative care, patient monitoring and mechanical assistance devices, micro-computers, and improved implants. Mr. Weinberg closed by emphasizing that there will be no demise of medical technology in the near future and that the two outstanding themes of technology of the 1980s will be "better quality" and "lower cost."

The second presentation, "The Government's Planned Approach to Technology: Efficacy Evaluation, Utilization Standards, and Reimbursement of Resulting Services," was given by John R. Ball, Senior Policy Analyst in the President's Office of Science and Technology Policy. Dr. Ball began by indicating that the government had no specified planned approach to health care technology, but would take a more active role in technology assessment. According to Dr. Ball, technology assessment would be different in the future with new methodologies looking beyond safety and efficacy issues to social, ethical, economic, and legal implications of new technologies; new laws concerning standards and norms for technology development and use; and new structure with public expectations increasing and a general shift from informal to systematic evaluation.

Dr. Ball noted that in the past the government left the issue of utilization to physicians, but was now interested in net medical costs and benefits of implementing new technologies. He said a new reimbursement system being developed to control health care costs would trade information in the form of special protocols for reimbursement of new technologies.

The third annual COTH Spring Meeting was held in Denver, Colorado, May 14–16, 1980. The meeting opened with a keynote address by Paul Ellwood, President of InterStudy, "Can Teaching Hospitals Services Survive in a Price Competitive Medical Care World?" He urged teaching hospital executives to assess the imminence of competition in their communities and prepare to enter the marketplace because open price competition among hospitals and attempts at product differentiation were coming, "like it or not."

The morning session on May 15 featured five presentations. Christopher Fordham, III, Chancellor of the University of North Carolina, attributed the nation's potential oversupply of physicians and shortage of nurses to the lack of collaboration between state and federal decision-makers in the health manpower area and the lack of adequate revision and goal setting. To address the oversupply, Dr. Fordham called for development of a national policy for reduction in health manpower over time; development of new approaches to the medical curriculum; and directly addressing the nursing supply issue within national policy. Edward J. Stemmler, Dean of the University of Pennsylvania School of Medicine, described medical schools' growing absolute dependency on organized faculty practice plan revenue for the financial support for medical education and emphasized the decreasing support from other traditional sources of funds. D. Kay Clawson, Dean of the University of Kentucky College of Medicine, described faculty practice plans as an effective mechanism for service, education, and research in a competitive market and emphasized "flexibility, accountability, and incentives" as keys to their success. Richard H. Moy, Dean and Provost of the Southern Illinois University School of Medicine, recounted the establishment of the new medical school and discussed its effects on area hospitals and communities. Julius R. Krevans, Dean of the School of Medicine of the University of California, San Francisco, presented a philosophical discussion on the current and prospective state of the nation in his speech on "Living in the Eighties: Where Do We Fit?"

The afternoon session began with an informative technical discussion of "Physician Reimbursement Issues in the Hospital-Based Group Practice Setting," by Jack C. Wood, attorney with Wood, Lucksinger & Epstein of Houston, Texas, followed by four concurrent sessions: Lawrence M. Klainer, Program Manager of the VA Central Office, discussed "Health Care Information Systems Within the VA," and Thomas B. Watt, Jr., Deputy, Planning and Program Development of the Central Office, spoke on "Multilevel Care: What, Why, How and When in the Veterans Administration;" Myron E. Wegman, Dean Emeritus, School of Public Health, University of Michigan, discussed "Bed Reduction Under State Legislation: The Michigan Experience;" "Third Party Pressure on the Academic Medical Center: The Stanford Story" was reviewed by Peter J. Levin, Executive Director, Stanford University Hospital; and Jerome H. Grossman, President of the New England Medical Center, presented "An Enterprise Approach to Managing the Hospital Outpatient Department."

The final day of the meeting was primarily devoted to a discussion of case mix reimbursement and the application of Diagnosis Related Groupings (DRGs). Judith R. Lave, Director of HCFA's Office of Research, spoke on "Fitting Payments to the Hospital's Product: The Medicare Perspective;" J. Joel May, Executive Vice President, Health Care Research and Education Trust of New Jersey, discussed "Case Mix Reimbursement: New Jersey's Approach to Assessing the Impact;" and Robert B. Fetter, Professor at Yale University and one of the original developers of the DRG concept, addressed the subject of "Diagnostic Grouping and Management: Changing the Questions Faced."

The COTH Administrative Board met five times to conduct the Council's business and to review and discuss all items on the agenda of the AAMC Executive Council. In its deliberations, the Administrative Board stressed five topics: the preliminary and final reports of the Association's Task Force on Graduate Medical

Education, the Association's revised statement on the expansion and improvement of health insurance in the United States, the reorganization of the Joint Commission on Accreditation of Hospitals with particular emphasis on its professional and technical advisory committees, the Association's project to describe and quantify the case mix and service characteristics of teaching hospitals, and the potential impact of competitive hospital pricing on teaching hospitals.

Preceding three of its meetings, the Administrative Board held informal discussions with three governmental health executives: Murray Grant, Medical Consultant, discussed the health activities of the General Accounting Office; Representative Richard Gephardt (D-Missouri) discussed his interest in developing legislation to promote cost containment through hospital competition; and Seymour Perry, Director of the National Center for Health Care Technology, described its developing programs.

Organization of Student Representatives

The OSR continued to expand its role as a disseminator of information to medical students across the country on issues of importance to them and as the means by which students' views are incorporated into the Association's activities and policy development. Once again this year 112 of the nation's medical schools participated in the Organization. At the 1979 annual meeting, 150 students from 97 schools exchanged views, shared concerns, elected officers, and passed resolutions on a variety of topics including greater emphasis in the curriculum on psychosocial aspects of health maintenance; changes in the reporting of National Board scores in the hope of decreasing faculty reliance on these examinations; encouraging AAMC to explore methods of gaining the input of house staff; and a call for more thorough and rigorous teaching of physical diagnosis skills. OSR's annual meeting program was titled "Options for Action: Career Decisions vis-a-vis Societal Needs" and provided attendees a useful framework for career decisions. OSR also offered discussion sessions on the medical school accreditation process coping with the residency selection process, interacting with nurses, working with the political process in health, and self-relaxation techniques.

The OSR Administrative Board met before each Executive Council meeting to coordinate OSR activities and to formulate recommendations on matters under consideration by the Council; in the latter category, the Board gave special attention to the Association's position paper on the expansion and improvement of health insurance in the U.S. and to the issue of competition as an alternative to increased regulatory control of hospitals and physicians. At its first meeting in January, the OSR Board invited AAMC staff to discuss with them many of the issues which formed the bases of their annual meeting resolutions, including "truth-in-testing" legislation, the Scarpelli v. Rempson, et al. case, National Board examinations and student participation in the medical school accreditation process. The Board also nominated students to serve on a number of AAMC committees, including the GSA Committee on Student Financial Assistance and the Minority Affairs Section Coordinating Committee. At a subsequent meeting, the Board nominated three students from among eighteen applicants for the position of student participant on the Liaison Committee on Medical Education.

Other activities of the Board included a continued examination of due process guidelines obtained from student affairs deans. In March members of the Board met with representatives of the National Health Service Corps Scholarship Program and the Armed Forces Health Professions Scholarship Program to explore the possibility of developing a one-for-one exchange option between the two service-commitment programs; the first step toward this goal was a letter to chief administrators in the Health Resources Administration and the Department of Defense recommending inclusion of language in the authorizing legislation to permit exchanges in cases of marriage. Another project undertaken was offering to the medical schools in the Northeast copies of the OSR-developed questionnaire for evaluation of residency programs in sufficient quantities to survey their most recent graduating class; the hope is to coordinate on a regional basis the inter-

institutional sharing of information on programs obtained from alumni. In addition, with the assistance of AAMC staff, the Board monitored developments relative to the renewal of the health manpower legislation, especially the student financial assistance provisions, with an eye toward generating letters from medical students in support of the AAMC's position at the appropriate legislative juncture.

During 1979–80, two issues of OSR Report were distributed to all U.S. medical students. The first was titled "Clinical Research: The Problem, The Opportunities" and described the growing need for M.D. investigators, the value of research experiences during medical school and the elective program at NIH; this issue also included a description of AAMC and OSR's role within it. The second issue was titled "The Residency Selection Process: Some Organizational Strategies" and offered advice about effective utilization of the NRMP Match and about the application and interview process.

National Policy

Over the past year, the formulation of national policy has taken place in an atmosphere characterized by pessimism about the ability of the federal government to define coherently its goals and to meet its responsibilities to the nation and the world. The gloomy economic picture has increased pressure to balance the budget while concerns about the international scene have strengthened the case for substantial increases in military spending, with a concomitant weakening of that for domestic social programs. The difficulty inherent in resolving these conflicting ends has been exacerbated by the political forces at play in an election year in which not only the Presidency, but all of the seats in the House of Representatives and one-third of those in the Senate are in contest. These circumstances have necessarily affected programs of significance to medical schools, their students and faculties, and teaching hospitals.

The Association has continued its efforts to maintain the partnership between the medical education community and the federal government. However, it is an uphill battle. Federal financial support of the programs of importance to the constituency of the AAMC has declined quite sharply over the last several years and the Association's staff has increasingly had to devote its energies to attempts to prevent, or at least limit, the harmful and often costly effects of proposed federal legislation and regulation.

Perhaps the issues most troublesome to the AAMC over the past year have been those related to the appropriations process, unusually complicated and confusing during the spring of 1980 as a result of the Congress's use of previously untested provisions of the 1974 Budget and Impoundment Act.

The President's request in January 1979 that the Congress rescind already appropriated funds for capitation grants, health professions student loans, and the National Institutes of Health unfortunately proved to be a harbinger of similar initiatives in 1980. In January 1980 the Administration twice requested similar rescission actions by the Congress. Vigorous efforts by the Association, its constituents and others contributed to a decision by the Congress to accede only partially to the President's request. After extended debate, Congress disapproved rescinding FY 80 funds appropriated for the NIH and for health professions student loans, but did agree to reduce capitation grants by slightly more than ten percent. While the end result can be viewed as a victory for medical education, given the prevailing economic climate, the battle once again raised doubts about the extent to which academe can rely on the federal government for any long-term commitments to medical education.

The President's recommended stringent, balanced budget for fiscal year 1981 did not contain good news for the individuals and institutions involved in medical education. The budget requested neither institutional support funds nor appropriations for the health professions student loan program. While the Administration did request an increase in funds for NIH competing research grants, it failed to provide any money for competing training awards.

The Association, together with the Coalition for Health Funding, has worked to increase to a more reasonable level the appropriation made by the Congress in the areas of medical education and biomedical and behavioral research. In comments to both the House and Senate Appropriations Committees, the Association urged that the fiscal year 1981 appropriation bill reflect that:

- Federal participation in the national education enterprise represents an appropriate and an important utilization of federal resources.
- Student assistance, in a variety of forms, has become an ever increasing necessity as the effect of inflation on tuition and living costs

places more students and their families under financial duress.

● While medical students face many of the same problems of other students, they must deal with certain circumstances—exceptionally expensive tuition, demanding schedules, few opportunities to supplement their resources—which create uniquely severe requirements for student assistance programs.

● The health and vitality of the nation's foremost research enterprise, the National Institutes of Health, rest largely in the hands of the federal government. The past successes and world renowned achievements of the NIH are strongly dependent upon the traditional generosity of the federal government in promoting the nation's health.

The current fiscal crisis has altered the focus of national policy concerning the delivery of health care services from assuring access to reducing the cost of such services. The national health insurance proposals introduced last year have been eclipsed by pro-competition proposals emphasizing health care cost restraint through marketplace incentives. Congressional interest in lowering the price of medical services has been tempered by a desire to develop an approach that minimizes direct government involvement; the significance of the latter factor was underscored by the sound defeat in the House of Representatives of hospital cost containment legislation that President Carter had considered to be the centerpiece of his anti-inflation program. The Administration has continued its efforts to control the cost of the Medicare-Medicaid programs through the regulatory process and the Association has worked to limit any unfairly detrimental impact upon teaching hospitals through regulations concerned with the implementation of Sections 223 and 227 of the Social Security Act, the reimbursement of hospital-based physicians and other issues.

The issue to which the Association has devoted the greatest attention in the past year is health manpower legislation. P.L. 94-484 expired at the end of fiscal year 1980 and the proposals for its renewal have been heavily influenced by an atmosphere of fixed austerity. Despite great disappointment in the way in which the government has met its commitments under this law, demonstrated by often meager funding and even outright rescissions of appropriations for these programs, the medical schools have continued to fulfill their obligations. Recent Congressional actions indicate that at least a few legislators are aware of the vital role played by medical educators in meeting important national goals and of the absolute necessity for federal support to enable the schools to address high priority national needs. However, the focus of health manpower legislation has shifted sharply due to changed conditions since the passage of the first manpower programs. No longer is the nation faced with a doctor shortage. Indeed, it is now believed in many quarters that the country is on its way to a surplus of physicians, even though concerns with respect to the geographic and specialty distribution of medical practitioners and the adequacy of the supply of providers of primary care remain.

Two markedly different proposals for new health manpower legislation have emerged from Congress. In addition, the Administration introduced a bill of very restricted scope and magnitude that was the subject of hearings but was not reported out of any committee. Congress was unable to meet the May 15 deadline by which all new authorizing legislation must be reported; thus, health manpower programs for fiscal year 1981 will almost certainly be funded by a continuing resolution.

The Administration proposal contained no surprises. Consistent with the President's recent actions with respect to appropriations, no institutional support was included in the measure and the Health Professions Student Loan program was eliminated. Except for the HPSL program, the Administration's bill retained, with minor modifications, both the student assistance structure and the special projects authority embodied in P.L. 94-484.

The House bill, sponsored by Rep. Henry Waxman, recommends a gradual phase-out of the capitation program over the next three fiscal years, eliminating only the present maintenance of enrollment requirement. The provisions related to special projects are also little changed from those contained in the present statute. In the area of student assistance, the House Interstate and Foreign Commerce Committee recommended the retention of the Exceptional Financial Need Scholarship Program

and the Health Professions Student Loan Program at generous levels; in addition, it amended the Health Education Assistance Loan program to increase borrowing limits, eliminate the interest ceiling, encourage lenders to allow a more reasonable repayment schedule, and permit a student to incur a GSL and a HEAL in the same year.

In the Senate a proposal was jointly developed by merging independent measures introduced by Senators Kennedy and Schweiker. One significant contribution of this bill is a new form of educational support under which medical schools would receive varying amounts of federal funds based upon the attainment of certain specified objectives. The aggregate level of funding provided for this new National Incentive Priority Grant Program is higher than that recommended by the House proposal for institutional support. Furthermore, Congressional enthusiasm outside the authorizing committee has already emerged for a program such as this. The special projects authority included in the bill bears a strong resemblance to current law. The student assistance component of the bill would, however, significantly revamp the present programs. In essence, it proposes a portfolio of student aid programs designed to meet the needs of students from the entire range of economic circumstances and to ensure that all but the most needy students bear substantial responsibility for payment of their education through repayment in either cash or national service. It proposes to extend and revise the Exceptional Financial Need Scholarship Program and HEAL Program; to reauthorize the National Health Service Corps Scholarship Program at a scaled down level; to phase-out the HPSL programs; and to establish two new service oriented programs. Under a service-contingent loan program, students would be eligible for partial subsidization of the interest rate and deferral of principal and interest during certain periods of time in return for a commitment to serve in national priority positions, if called.

In testifying on health manpower legislation, the Association emphasized the responsibility of the medical schools to offer high quality medical education, the need to avoid limiting access to medical education to the affluent, and the fairness of sharing equitably the cost of the medical education system among all its beneficiaries: students, the general public, and local, state and federal governments. The testimony stressed that because medical schools are continually and to a significant degree engaged in public service activities benefiting the whole nation, the federal government should provide a balanced portfolio of student assistance programs, basic institutional support and an array of cost reimbursement special project awards designed to address high priority national goals.

In Congressional appearances the Association addressed various proposals with respect to the admission of alien foreign medical graduates to graduate medical education programs and the problems faced by certain hospitals that depend on FMGs to provide medical services. The Association supported the recommendations to extend the allowable period of training for exchange visitors under the J-visa to permit an alien physician to complete a training program in a given specialty or subspecialty. However, the AAMC strongly objected to proposals to extend the VQE waiver period on the grounds that it would be a disservice to medicine, to medical education, to the general public and especially to the urban poor. In addition, various bills provided for the placement of National Health Service Corps physicians to assist hospitals in decreasing their reliance upon alien FMGs. While the Association vigorously opposed any attempt to permit physicians who had held NHSC scholarships to credit the time spent as residents in these hospitals toward the service payback obligation in their scholarship agreements, it did support the assignment of fully-trained Corps physicians to these troubled institutions. The Association stressed that over the long-term the real solution to the health service delivery problems resulting from the changes in immigration laws is improvement of the quality of graduate medical education offered by these hospitals to the degree necessary to attract U.S. graduates.

The Association also emphasized that the graduate medical education problems in urban hospitals are really a by-product of the serious problems of poverty and the economic decline of many of our cities. The Health Subcommittee of the House Ways and Means Committee held hearings on the financial crisis facing both public and private urban hospitals that primar-

ily serve the medically indigent. The AAMC and others concerned with this situation have recommended that the committee consider modifications to current Medicare-Medicaid reimbursement policies that impact adversely on urban hospitals and that all Public Health Service Act funds be allocated to enable these institutions to replace outdated and aging physical plants. In addition, the Association would urge that federal funds be deployed to improve graduate medical education programs.

The Association has focused upon several other collateral issues related to student assistance. The reauthorization of the Higher Education Act has received considerable attention in Congress over the past year. This legislation is of interest to medical education because it includes the Guaranteed Student Loan Program, which represents the major source of loan funds for medical students. Both the Senate and House have passed measures that propose several favorable changes to the existing loan program, including a substantial increase in aggregate borrowing limits. A few problems remain to be resolved before approval of the conference report.

The attractiveness and usefulness of some of the existing scholarship programs for medical students, established to address certain physician shortage situations, had been compromised by the failure to resolve definitively the issue of their tax status. Several years ago, the Internal Revenue Service ruled that awards made under both the National Health Service Corps and Armed Forces Health Professions Scholarship Programs were taxable as income because of the nature of the service requirement of these programs. Congress, however, delayed enforcement of this IRS ruling by enacting a temporary moratorium on the taxation of these scholarships. The House has recently passed a bill providing a tax exemption for that portion of awards covering tuition and fees, but the portion of the stipend for living expenses will be subject to income taxation. Another program covered by a similar moratorium on taxation, the National Research Service Award Program, was not included in the House measure, but is currently under consideration in the Senate. Only recently has NIH found it possible to raise the stipends for both pre- and postdoctoral trainees to competitive levels; taxation of the totality of these stipends would undermine the positive effects of this recent change The Association has strongly supported efforts to extend the temporary provision for favorable tax treatment of NRSA awards.

Another issue of critical importance in the field of manpower is the attempt, through both the federal courts and legislature, to define interns and residents as employees for the purpose of the National Labor Relations Act. By a decisive margin, the House of Representatives in late November 1979, voted its disapproval of a bill (H.R. 2222) that would have accomplished that result. The Association has long opposed such legislation on the grounds that it would effectively destroy the educational environment so essential in graduate medical education by replacing it with an adversarial employer-employee relationship.

The Association's position that house staff are primarily students was also accepted by the U.S. Court of Appeals for the District of Columbia in its recent decision in the *Cedars-Sinai* case in which the Association served as *amicus curiae*. In an appeal by the Physicians' National Housestaff Association from a district court ruling that it had no jurisdiction to review the National Labor Relations Board's determination that interns and residents are not employees for the purposes of the National Labor Relations Act, the Court of Appeals affirmed the lower court finding that the NLRB had acted within its statutory authority.

An important issue related to the medical school admissions process has recently emerged and preempted extensive AAMC staff effort. In well over a dozen states, as well as in the national legislature, bills requiring public disclosure of all standardized test questions and answers, including those in the Medical College Admission Test have been introduced. To date, vigorous staff efforts, together with the cooperation of the member schools, have averted the enactment of new statutes. The AAMC has challenged the constitutionality of the disclosure provisions contained in the statute dealing with standardized testing passed by the New York state legislature in 1979. The Federal District Court has temporarily enjoined the enforcement of these provisions; therefore, the MCAT examination will be offered in New York as long as the judicial relief lasts.

The close ties built up over the last three decades between many medical schools and Veterans Administration hospitals have stimulated the keen interest of AAMC staff in the programs and policies of that agency. The Association was heartened by Congressional action to override a Presidential veto and enact permanent special pay authority for VA physicians. In its testimony the AAMC had endorsed the need for increases in special pay, the desirability of granting the VA permanent authority to establish special pay agreements, and the exemption of VA physicians from assimilation into the new Senior Executive Service.

The amendments to current law expanding incentives for full-time physicians are clearly worthy of support. However, the AAMC expressed strong opposition to the exclusion of the part-time physicians who devote most of their efforts to the VA from eligibility for these benefits. In a related matter, the Association was disappointed with the new Uniformed Services Health Professionals Special Pay Act of 1980 because Public Health Service physicians, who in the past had been treated on the same basis as other members of the uniformed services, will not be eligible for the increased rates of compensation made available to military physicians. The Association has advocated that the PHS be economically competitive if it is to continue to be able to attract gifted physicians into its ranks.

In another matter of importance to physicians and schools of medicine affiliated with VA hospitals, the Association presented testimony at an oversight hearing held by the Senate Committee on Veterans' Affairs concerning the activities of the VA Inspector General. The primary concern of the Association related to the manner in which the field staff of the Inspector General carry out their responsibility to eliminate fraud, abuse, waste and mismanagement in VA Hospitals. The heavy handed tactics used by some investigators have intimidated VA personnel and created tension in the otherwise productive relationships between the VA and affiliated medical schools. The Association emphasized the importance of respecting the rights of individuals under investigation and the need for the staff of the Inspector General to develop an understanding of the nature of medical practice and of the complexities of the affiliation relationships between the VA and the medical schools.

As in past years, legislation and regulation relating to biomedical research have captured a very substantial fraction of the Association's energy and resources. Of considerable concern to members of the biomedical research community have been proposals to restructure the NIH through amendment of Title IV of the Public Health Service Act. The Association has worked long and hard to inform Congress about the potential problems that might ensue upon enactment of such proposals and has called attention to the failure of the proponents of these measures to provide a valid justification for tinkering with an agency that has served the country so well for so long a period.

Senator Kennedy and Representative Waxman each introduced bills to establish the NIH formally in law, but the provisions in these long and complex measures are markedly different. The Kennedy bill (S.988) was approved by the Senate by a virtually unanimous vote; it places primary emphasis on planning, and establishes a President's Council for the Health Sciences with a mandate to develop annual plans for alternative proposed budgets for health research and spending priorities for the four following fiscal years. The Association opposed the planning function as largely redundant of efforts currently performed in the executive branch and as an unnecessary complication to the already enormously complex budget process.

The Waxman bill (H.R.7036) was approved by the House by a vote of 292–48. Its most noxious provisions include time-limited authorizations and appropriation ceilings for all NIH Institutes and, in addition, deny these organizations access to the broad authorities in Section 301. In marking up this proposal, the Committee on Interstate and Foreign Commerce did address several of the concerns voiced by the Association in its testimony on the bill: the extent to which contracts would be subject to peer review was somewhat modified and unworkable requirements for peer review for intramural research were replaced with an acceptable procedure to achieve that objective. However, the Association is unalterably opposed to the removal of permanent time and dollar authorities. Such a change could wreak

havoc in the research community in light of the perennial problems facing programs with short-term authorities—crowded legislative agendas combined with renewal deadlines. Moreover, the enactment of these provisions could politicize the national biomedical research program to a devastating degree.

The Association has also reviewed and monitored other legislation that could also pose real problems for the NIH in the administration of its responsibilities. One such bill, "The Research Modernization Act," has the general aim of developing alternative methods of research and testing that would obviate the need for live animals in biomedical research. This proposal would establish a National Center for Alternative Research, empowered to mandate policy and procedures to federal agencies involved in research and testing that use live animals. Furthermore, it would require that no less than 30 percent of all appropriations made available to an agency for research and testing involving the use of live animals be used for the development of alternative methods of research. The Association has apprised the bill's sponsors of the problems the bill would engender.

Yet another proposal, the Small Business Innovation Act, sets forth requirements that would be impossible for the NIH, and perhaps other federal agencies, to meet. In an attempt to nurture small business, this legislation contains provisions that would require that amounts eventually reaching a fixed percentage of each of the federal agencies' research and development budgets be awarded to small businesses. The amount of this set-aside would be computed as a percentage of appropriated funds awarded for contracts, grants and cooperative agreements. Thus, the entire NIH extramural research budget would be the base upon which the set-aside would be calculated. Since the NIH would have to meet its obligations under this legislation through the contract mechanism, the small business portion could assume 50–75 percent of the funds available for contractual agreements. It is inconceivable that the NIH would be able to meet the requirements of these measures since few small businesses can marshall the skills and resources necessary to provide the kinds of services obtained through NIH's R&D contracts. Both Small Business Committees have reported out bills that mandate such set-asides for small business firms and that fail to take into account the deleterious impact of the scheme on biomedical research. The Association has endeavored to inform the Congressional committees with jurisdiction over the programs of the NIH of this troublesome situation, urging them to remedy it.

The AAMC joined three individual scientists, the American Society of Biological Chemists, the American Council on Education and the California Institute of Technology in the preparation and submission of an *amici curiae* brief in *Diamond v. Chakrabarty,* a case dealing with the patentability of a microbiological product of genetic research. The Board of Patent Appeals' denial of a patent was overturned by the United States Supreme Court when the latter ruled that a live, human-made microorganism is patentable subject matter. The Court adopted the position espoused by the inventor and endorsed by the Association that the fact that the organism was alive was without legal significance for the purpose of the patent law. In the Court's view, Congress recognized that the relevant distinction was not between living and inanimate things, but between products of nature and human made inventions, whether living or not. Failure to provide patent protection for such inventions would have seriously limited the attractiveness of research in this area.

The protection of human subjects in biomedical and behavioral research has been at issue in several regulatory matters. The Association has been particularly concerned about the proposed regulations of both HHS and FDA governing the activities of Institutional Review Boards responsible for the protection of research subjects. The principal recommendation of the AAMC in commenting on these proposals is that one uniform set of regulations be issued to avoid any incompatibility between FDA and HHS requirements that would increase the already difficult task facing the IRBs.

The question of compensation for subjects injured in research has been placed on the agenda of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the successor to the HHS Ethics Advisory Board. DHHS has under serious consideration a pro-

posal to mandate insurance coverage as a condition for the award of research grants. The proposition that research subjects, injured in the course of endeavors directed toward improving the general welfare, ought as a matter of ethics and good public policy, to be made whole to the extent possible, is one which attracts almost universal and intuitive approval. However, the difficulties involved in developing a possible program to accomplish this goal are enormous. It is currently impossible to purchase insurance coverage to provide such compensation, a fact that has understandably alarmed research institutions.

In a related matter, the protection of the privacy interests of individuals whose medical records are used in epidemiologic and other health research projects has been an issue in proposed legislation. In Congressional testimony on the bill to insure confidentiality of medical records, the Association has emphasized the importance of the availability of individually identifiable medical records in many epidemiologic studies and the significant barriers to both research and public health practice that would be created, should investigators be required to obtain prior patient consent in order to obtain access to records. During the markup of this legislation by several committees of the House of Representatives, the exemptions for research sought by the AAMC have come under considerable attack; the Association has continued to work with members of these committees to assure that reasonable access for biomedical research purposes is provided and that the role of the IRBs in protecting the privacy of research subjects is not undermined.

The Association has also examined and commented on other legislative and regulatory matters that would impact on the scientific community including: the Public Printing Reorganization Act that could give the Government Printing Office almost complete control over the publication and distribution of all materials classified as public documents; the Recombinant DNA Research and Development Act of 1980 that attempts to regulate private research and development involving recombinant DNA techniques; bills establishing sites for the disposal of low-level nuclear waste; legislation and regulations concerning personnel standards for clinical laboratories; the NIH and OSHA documents related to handling of carcinogens in the workplace; and drug reform legislation.

As this year draws to an end, many issues of overriding importance to medical education remain unresolved. Outstanding among these are health manpower legislation and the redefinition of the operating authorities of the NIH. Intervening events—the state of the economy, the effect of the election on the composition of the House and Senate and on the leadership of the executive branch—might modify the complexion of the situation drastically. Whatever the outcome the Association will continue to represent with fidelity and vigor the aspirations, needs, problems and attitudes of medical education.

Working with Other Organizations

Since 1972 the AAMC has worked with the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, and the Council of Medical Specialty Societies as a parent member of the Coordinating Council on Medical Education. The CCME has served as a forum to discuss medical education issues and to recommend policy statements to the parent organizations, and has reviewed the activities of the Liaison Committees charged with accreditation responsibilities.

In July the top elected official and chief executive officer of the five CCME parents met in Chicago to consider the future role and structure of the organization. Far-reaching discussions resulted in a tentative agreement that CCME would be replaced by a Council for Medical Affairs. The new organization would not have a direct coordinating role over accreditation. This new proposal must be discussed by each parent organization before final adoption.

Since 1942 the Liaison Committee on Medical Education has served as the national accrediting agency for all programs in medical education leading to the M.D. degree. The LCME is sponsored by the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges. Prior to 1942, and beginning in the late nineteenth century, medical schools were reviewed and approved separately by the AAMC and the AMA. The LCME is recognized by the physician licensure boards of the 50 states and U.S. territories, the Canadian provinces, the Council on Postsecondary Accreditation and the Department of Education.

The accrediting process assists schools of medicine to attain prevailing standards of education and provides assurance to society and the medical profession that graduates of accredited schools meet reasonable and appropriate national standards; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated. Survey teams provide a periodic external review, identify 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 1980 there are 126 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences and 10 have not yet graduated their first classes and consequently are provisionally accredited. The 116 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 Examination.*

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 advisers.

For the Liaison Committee on Graduate Medical Education, this year was one of both progress and new challenges. Through more effective staff work, improved scheduling of program surveys made it possible to increase the number of residency programs reviewed by the Residency Review Committees. The backlog of programs overdue for accreditation by the LCGME was reduced. The number of appeals by programs placed on probation or not accredited has grown substantially. The appeals procedures of the LCGME have functioned only with difficulty and are being reviewed to facilitate the process while still ensuring fairness.

The LCGME forwarded to the Coordinating Council on Medical Education a recommendation that the accreditation of graduate medical education be financed through revenues generated by a combination of an annual charge to programs based upon the number of positions offered and charges for periodic survey and review. If accepted by the sponsoring organizations, the LCGME will have a more secure financial base for its accreditation responsibilities. Sponsoring organizations would continue to pay the costs of their representatives' attendance at meetings and the costs of LCGME policy development activities.

Discussions were held by the LCGME Steering Committee with officials of the American Medical Association to reach agreement on the role and responsibilities of the staff assigned to serve the LCGME. These discussions resulted in greater participation by the LCGME in selecting its Secretary and specifying the Secretary's responsibilities.

Two changes in its bylaws were sent forward to be ratified by the LCGME sponsors. An amendment to establish an executive committee empowered to act for the LCGME between meetings was rejected. Awaiting final approval is an amendment to increase the number of representatives from the Council of Medical Specialty Societies and American Hospital Association to four each, giving them parity with the AAMC, the American Board of Medical Specialties and the AMA.

A subcommittee on improving the accreditation process recommended that the LCGME and the Residency Review Committees establish an accreditation mechanism for subspecialties for which special competency certification is provided by a specialty board. Planning to implement this recommendation is now in process.

The proposed revision of the general requirements section of the Essentials of Accredited Residencies sent forward last year was not ratified by one sponsor; several modifications were also requested by other sponsors. Consequently, another special conference committee composed of representatives of the CCME and the LCGME was established to resolve the differences among the sponsors. Modifications acceptable to all representatives were agreed upon and the general requirements are now awaiting a second round of ratification decisions.

In February the American College of Surgeons forwarded to the LCGME, through the Council of Medical Specialty Societies, a proposal that the surgical specialties should review and consider changing the sponsorship of their Residency Review Committees, develop a separate staff to serve the surgical Residence Review Committees, and have the Residency Review Committees reassume the accrediting authority for graduate medical education programs in surgery. It was proposed that the LCGME function only as an appeals body. Discussions at the March Council of Medical Specialty Societies meeting modified the proposal. It is anticipated that CMSS will make several recommendations for changing the accreditation process. The evolution of these recommendations and their impact upon the future of graduate medical education accreditation is not yet clear.

The Liaison Committee on Continuing Medical Education, after the withdrawal of the American Medical Association, reorganized its staffing and accreditation process. Simultaneously it initiated procedures to review and revise the present statements regarding principles and quality of continuing education (Essentials) with the intent of improving the effectiveness of accreditation of continuing medical education and of strengthening the role of the LCCME as a promotor of innovation and advancement in this field. The translation of the conceptual relationship between physician learning, competence, performance and the quality of health care into definable, discrete

educational activities and quality assurance programs, is a challenge that requires a sustained effort from many quarters. A project being carried out jointly by the AAMC and the Office of Academic Affairs of the Veterans Administration should prove helpful in this context by developing suggestions regarding the cooperative nature of continuing education involving the individual physician and the education provider institution and organization. In anticipation of reorganizing the LCCME as a reunified accreditation body, the theoretical and conceptual basis for its further operations is being developed.

As a member organization of the Educational Commission for Foreign Medical Graduates, the AAMC is participating in a review of the Commission's role and functions on the present scene. The ECFMG continues to be responsible for assuring that foreign medical graduates entering U.S. graduate medical education programs meet minimal standards of preparation and competency for benefiting from the education offered and for participating in patient care programs. Further, by a contractual arrangement with the International Communications Agency of the Department of State, the ECFMG acts as the sponsor of the visitor exchange program for physicians. Thanks to its extensive computerized information system, it also serves as a major source of information on the flow of FMGs into this country. In addition, the ECFMG administers under contract with the National Board of Medical Examiners the Visa Qualifying Examination required of alien foreign medical graduates to qualify for either temporary exchange or permanent immigration visa.

The Coalition for Health Funding, which the Association joined with others in establishing ten years ago, has expanded its activities and influence by monitoring and commenting on the development of the Congressional budget resolutions in addition to the traditional efforts on the appropriation process. Efforts continue to refine the processes 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 consituency 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.

A joint meeting of the Executive Committees of the AAMC and the Association of Academic Health Centers was held in April to discuss ways in which the two organizations could work together more closely. The AAHC described its particular interest in becoming more active in issues relating to teaching hospitals. The AAMC agreed to include AAHC members in its distribution of policy memorandum. The AAHC study on "The Organization and Governance of Academic Health Centers" was reviewed and critiqued by AAMC Administrative Boards.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with members representing both the educational and professional associations of eleven different health professions. This year FASHP has been especially concerned with new health manpower legislation and state and federal legislative proposals to regulate standardized testing. The Association also works closely with the staff of the American Association of Dental Schools on matters of mutual concern.

At the 1980 annual meeting of the National Board of Medical Examiners, the Comprehensive Qualifying Evaluation Program was presented for preliminary review and approval to move forward with implementation. The Comprehensive Qualifying Evaluation Program is an outgrowth of the 1973 NBME Goals and Priorities Committee report which recommended that there be a qualifying examination at the interface between undergraduate and

graduate medical education. Students would be required to pass the exam to enter the graduate phase of their education. Eventually this qualifying examination would replace the three part sequence of examinations provided by the Board since the early 1920s. The Comprehensive Qualifying Evaluation Program consists of a cognitive examination and an assessment by faculties of the clinical skills and competencies of their students. At the Board meeting AAMC representatives expressed concern about the need for wide dissemination of information about the characteristics and utility of the Comprehensive Qualifying Evaluation Program to the faculties and urged that the Board develop a process to accomplish this.

To facilitate the interaction between the Board, the AAMC, and its constituents, an *ad hoc* External Evaluation Review Committee was appointed. The committee was also asked to study a proposal by the Federation of State Medical Boards to develop a two step licensure process with the first step requiring passing an examination such as the Comprehensive Qualifying Examination to qualify for a limited license to participate in patient care in a supervised graduate medical education program. The second, for full licensure, would require passing another examination after one or two years of graduate medical education. The committee is expected to report its recommendations to the Executive Council in 1981.

The Association has continued its involvement with the Pan-American Federation of Associations of Medical Schools, which began in 1961 when the AAMC played a key role in its establishment. An AAMC delegation will attend the November conference in Panama on "Strategy for the Preparation and Utilization of the General/Family Practitioner."

Education

The Task Force on Graduate Medical Education, appointed in 1977 to study the issues surrounding graduate medical education, completed a report entitled, *Graduate Medical Education: Proposals for the Eighties.* Under the chairmanship of Jack D. Myers, Professor of Medicine at the University of Pittsburgh, the Task Force and its five working groups involved over 70 key individuals concerned with improving the quality and availability of graduate medical education for the expanding number of students graduating from U.S. medical schools.

Each working group drafted a chapter of the report. The chapter titles are The Quality of Graduate Medical Education, The Transition Between Undergraduate and Graduate Medical Education, National Standards Formulation and Accreditation of Graduate Medical Education, Specialty Distribution and Graduate Medical Education, and The Financing of Graduate Medical Education.

At the 1979 annual meeting a representative of each working group presented the major findings and recommendations contained in each chapter to a special Assembly session. The responses from members of the Assembly were largely supportive, although concerns were expressed regarding several issues. One was how the relative autonomy of many major teaching hospitals was to be recognized in defining a medical school and its network of teaching hospitals as an academic medical center. Another was whether the recommendation that academic centers should attempt to adjust the mix of specialists trained in their institutions to meet perceived local, state, regional, or national needs could be accomplished locally by the centers. A third issue was how to resolve the debate over the balance between education and service in graduate medical education programs.

Subsequent to the Assembly discussion, the Task Force modified the report to deal with concerns which were expressed and presented it to the Executive Council for endorsement. The Council decided to disseminate the report widely as a working document and to sponsor an invitational conference of representatives from specialty certifying boards, specialty societies, the LCGME and its sponsors, and key individuals concerned with national graduate medical education policy. The conference was held in Washington, D.C. on September 29 and 30.

In 1979 the Executive Council decided to sponsor periodic meetings for residents to gain their perspectives on issues in graduate medical education. Thirty-two residents were selected from a list of nominees provided by the deans of the medical schools and the Organization of Student Representatives. At the first conference, in October of 1979, the residents reviewed the preliminary draft of the report of the task force on Graduate Medical Education. Their discussion and critique of the document provided useful insights which were used by the Task Force. A second conference is scheduled for January 1981 when thirty-six residents and eighteen representatives from specialty boards and specialty societies will discuss problems in evaluation in graduate medical education.

In concert with the emphasis of the Association in the area of graduate medical education the Group on Medical Education has dedicated more attention to this area. One significant dimension of the effort was a meeting sponsored by the GME Steering Committee with representatives from various specialty groups heavily involved in residency education. The enthusiasm generated at that meeting for collaborative efforts with the GME has found initial expression in a jointly sponsored program at the annual meeting on evaluation issues for program directors. Discussions at the meeting also focused on the importance of enhancing communication with faculty responsible for the education of residents. In this

regard the GME found it important to review the definition of the role of graduate medical education appointments to the GME as a necessary step in strengthening communication with faculty directly engaged in clinical education.

At a more specific level, the GME established a new Technical Resource Panel to study educational programs for students who have had part of their medical education outside the U.S. system. This panel will review the objectives and content of fifth pathway programs, entry and exit criteria, and ways in which the performance of such students is assessed.

In addition to these activities at the national level, regional GME initiatives have intensified the focus on issues in graduate medical education. Plenary and small group sessions examined topics such as the process of accreditation in graduate medical education, the development of the Comprehensive Qualifying Examination as an assessment of readiness for graduate training, the impact of curricula on career choices, problems in the coordination of family practice residencies, and a review of the AAMC Task Force Report on Graduate Medical Education.

Besides these targeted programs, the Research in Medical Education Conference continues to serve as a forum for discussion of many graduate education issues, where papers are presented on topics such as an examination of teaching behaviors in the clinical setting, the impact of residency programs on career outcomes, and the development and evaluation of clinical problem-solving skills. The symposia sessions have examined issues of current interest such as the impact of government initiatives.

While these activities have been evolving in the GME, AAMC staff have been pursuing related projects. The first report of the AAMC Clinical Evaluation Project examined "The House Officer as a Teacher: What Schools Expect and Measure." Specialty-specific reports describing evaluation practices and problems of clinical faculty involved in assessing the performance of clerks and residents will be available for internal medicine and surgery in the near future; reports for pediatrics, psychiatry, obstetrics/gynecology and family medicine will follow.

The information received from clinical faculty from approximately 500 departments is being placed in the Clinical Evaluation Project data bank. Departments in which similar evaluation problems exist will be identified with the use of the data bank. Clinical faculty identified with the use of the data bank will then be invited to participate in various research efforts focusing on specific evaluation problem areas.

A program of research on the Medical College Admission Test focuses on the full range of formal medical education. These interpretive studies will be conducted with institutions that are representative of the admissions practices, curricular approaches, and student assessment systems used in U.S. schools of medicine. Currently, twenty-seven schools participate in the Medical College Admission Test Interpretive Studies Program with four schools scheduled to join the program in 1981. The AAMC and the participating institutions are establishing a research database to facilitate the conduct of MCAT-related cooperative studies. The initiation of local validity (interpretive) studies, based on research plans developed by each institution, will occur in the fall of 1980. Additional studies are being undertaken by staff on the national cohort in an effort to provide additional information on the interpretation of MCAT scores.

The results of such research will facilitate a more informed and documented use of MCAT score information in various institutional settings and provide invaluable data to AAMC in its continuous effort to monitor and evaluate the test.

While these efforts to enhance evaluation proceed, destructive efforts to regulate standardized testing continued at both state and federal levels. H.R. 4949, introduced into the Congress in 1979 by Ted Weiss (D.-N.Y.), was withdrawn by the sponsor in October when favorable committee action appeared doubtful. Additional hearings were conducted in the spring of 1980 primarily to review developments in New York following the enactment of similar legislation there. The AAMC once again presented testimony in strong opposition to the bill and brought to the attention of the Congress its judicial action in the Federal District Court of New York. There the AAMC was granted a preliminary injunction protecting the MCAT from the enforcement of the New York

law while its constitutionality was tested. This action made it possible to continue to offer the MCAT in New York.

Meanwhile other states looked with varying degrees of interest into similar legislation. Twenty-three considered bills but none took favorable action. The AAMC will continue to monitor these proposals at both state and federal levels and continue to offer its assistance to the schools in opposing this legislation.

Pursuant to a decision by the Executive Council to undertake a major review of the status of medical education, planning began to study the general professional education of physicians during both the baccalaureate and medical school phases of their education. The project will be founded on the concept that all students progress from medical school into graduate medical education and will particularly focus on how to prepare students most effectively for their graduate education.

Medical schools share with other organizations, particularly specialty societies and hospitals, the major responsibility of providing planned programs for continuing education of physicians. The exploration and development of mechanisms by which such programs can blend with and contribute to individual study requirements of physicians and contribute towards maintaining or extending physician competency and quality performance, represent an exciting challenge to medical education in general and faculties of medical schools in particular. The Continuing Education Systems Project, a joint endeavor of AAMC and the Veterans Administration, is developing a conceptual framework and guidelines for supporting the efforts of the physician as an adult professional learner through organizational or institutional program planning. This project represents a direct follow-up to recommendations of the ad hoc Committee on Continuing Medical Education approved by the Executive Council last year.

Medical schools and their related medical or health sciences centers expend much effort and resources producing educational materials and providing facilities for their utilization in the educational process. Despite rapid development in the field of communication technology, the application of this technology to learning and curriculum planning is uneven and frequently uncontrolled. The AVLINE project to develop an information system on mediated instructional materials was jointly launched by the National Library of Medicine and AAMC some years ago. Presently AVLINE offers on- and off-line searches combining bibliographic and critical review information for audiovisual educational materials in AVLINE, a broader consensus on attitudes of quality of such materials available in the health professions. However, in order to develop a conceptual basis for a meaningful critical review, a system of educational materials had to be developed. AAMC, in collaboration with the National Medical Audiovisual Center and the Veterans Administration, has launched an effort to define quality in terms useful for production, evaluation and utilization of mediated educational materials. For AVLINE the potential availability of nationally acceptable criteria for quality of mediated instructional materials will be helpful in improving the critical review process of items entered into this data base. Presently 9,000 entries in AVLINE cover the health professions disciplines; 67 percent of these entries address topics in clinical medicine. Nevertheless, the utilization of these resources is uneven among and within institutions. Some of the dynamics of the utilization process are presently under study.

Biomedical Research

Biomedical research in recent years has been marked by an accelerating pace of new discoveries of both basic and immediate practical importance. These positive results are the fruits of several decades of unparalleled research support, but they have been matched in the past year by an accelerating rate of inflation, by the threatened erosion of the research budget by Presidential rescission of appropriated funds, by the uncertainty of research training funds for fiscal year 1981, and by very serious legislative threats to the autonomy and managerial stability of the National Institutes of Health.

In January 1980, the President proposed to reduce 1980 research funding by rescinding funds already appropriated by the Congress for a broad array of health related programs. The President then proposed increases above the reduced 1980 base for the 1981 fiscal year. The objective of the President's proposed 1981 budget was to assure funding of at least 5,000 investigator-initiated research projects each year; however, the funds to achieve this goal were to be taken from research training, research centers and contracts. No funds were requested for competing renewals or for new individual or institutional awards in research training. The Association, in coalition with other national associations, worked vigorously to persuade the Congress to reject the 1980 rescission proposals and to add additional funds to support new starts in research training programs for fiscal year 1981.

Added to the adverse effect of funding uncertainties and rapidly escalating inflation on the national biomedical research enterprise were legislative actions of the Congress which threatened the structure and function of the National Institutes of Health (NIH). Both the Senate and the House of Representatives, spurred by the necessity to renew the expiring authorities for the Cancer and Heart, Lung and Blood Institutes and certain other programs, fashioned bills which went much further than simple reauthorization and which established the NIH in law for the first time. The Senate bill was introduced in 1979. After much debate and discussion with the research community, the legislative proposal of the Senate was significantly improved before its passage in 1980. The House bill, in contrast, was introduced in February 1980, and passed through the legislative process with little opportunity for input from the scientific community. Like the Senate bill, the House bill also proposed to establish the NIH in statute but, in addition, it proposed three year authorizations and appropriation levels for each Institute. Further, many changes in the structure of NIH were proposed which taken together would seriously compromise the ability of NIH to meet current and future goals. The Association, cooperating with other groups, sought to modify the House bill to remove these provisions and to render the NIH less susceptible to politicalization.

During the past year the Association stepped up its activities to counteract the developing shortage of clinical researchers. A 1979 report of the Association's *ad hoc* Committee on Clinical Research Manpower had made a number of recommendations for gathering data and disseminating information about the decline of interest of physicians in research and academic careers. The report was widely discussed at the interim meetings of the deans, student affairs officers, premedical advisers and medical school faculty. Members of the committee and the Association staff participated in conferences sponsored by the AAMC, the Institute of Medicine, the University of Chicago, the NIH, the clinical research societies and the New York Academy of Medicine. In addition, research suggested by the committee is being conducted by the Association to provide better understanding of and data about the preparation of physicians for research and faculty careers. There are some signs that the situation may be stabilizing or even improving slightly.

The Association continued to monitor legislative and regulatory actions relating to clinical laboratories to assure that research laboratories would not be inadvertently and adversely affected by efforts to improve such laboratories. And, largely through Association efforts, the issue of the compensation of human subjects injured in the course of research was referred to the DHEW Ethics Advisory Board and, later, to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. This very difficult ethical dilemma is now receiving the careful study of the latter Commission.

Health Care

The increased reliance of medical schools on income generated by faculty practice plans has made physician services provided in the academic medical center, once a matter of individual preference decided by faculty, a matter of institution-wide concern. Ambulatory care services in teaching hospitals, formerly donated to the local community with losses being absorbed elsewhere in the hospital, have been expanded, and reorganized ambulatory centers are now marketing their services to all sectors of the community. Major teaching hospitals of academic medical centers, formerly standing as preeminent referral centers for tertiary care in their area, are now experiencing a degree of competition for complex cases from nearby community hospitals where well trained subspecialists now offer highly technical, sophisticated services. When to all this is added a changing health care environment characterized by disenchantment with regulation, new interest in allowing "marketplace" forces to influence and determine the organization and delivery of care, and by increasing support of both government and industry for prepaid practice as well as other alternative arrangements for the delivery of care, the questions of developing relationships between components of the academic medical center and health maintenance organizations have become of high interest to deans, faculty members, and hospital administrators. A national conference, co-sponsored by the Kaiser Family Foundation and the Association of American Medical Colleges in October 1980, addressed questions concerning the organization and financing of HMOs, their effect on medical education, and faculty practice plans.

This conference provided participants with background on the potential benefits and risks of involvement and/or affiliation between academic medical centers and prepaid practice so as to assist in the decision as to the most appropriate form for a relationship between an institution and prepaid practice. It is expected that proceedings from this conference will be published in early 1981.

During the fall of 1980 the final draft of textbooks for faculty and students on quality assurance and cost containment were readied for publication. This effort, sponsored by the AAMC under a grant from the Health Care Financing Administration and in collaboration with the Johns Hopkins University, culminated in twin publications. The first, a general resource book for faculty, presents a comprehensive review of the information and framework needed to carry out quality assurance and cost containment activities, and provides detailed description of the sequence of activities to be followed in conducting studies in practice situations. It reviews existing quality assurance and cost containment programs in U.S. medical schools and provides strategies for implementing and evaluating such educational programs. The companion text is a more condensed and simplified primer for students and residents. It describes the essential elements of general quality assurance methods and critiques various techniques currently utilized. Case studies illustrate how to evaluate quality and manage resource utilization. Both texts have been in production for two years. Extensive field testing among students, residents and faculty preceded the final drafts.

Faculty

The Administrative Board of the Council of Academic Societies voiced its concern about the apparent decline in clinical research manpower in June 1979, and at its suggestion an ad hoc committee was formed to consider this matter. The committee's report was adopted by the Executive Council in January 1980, and its recommendations disseminated to the AAMC constituency and to others.

A key recommendation of the committee was that the Association collect data and conduct studies of the problem. Consistent with this recommendation, the AAMC applied for and received a contract from the Commission on Human Resources of the National Academy of Sciences to conduct several studies pertaining to the supply, training and career-long research productivity of clinical investigators. One study will survey the amount of time spent in research and research-related activities by M.D.s on the United States medical school faculties, based on a random sample of full-time faculty stratified by department and year of graduation from medical school. By collating the survey responses about current research activity from physicians at different stages in their careers, a career-long research involvement profile will be generated for physicians in each of five groups of departments. Research publication activity of the surveyed faculty will also be analyzed as part of the first study. Career productivity profiles will be used with faculty age and turnover data to project future clinical research output.

Another study being performed for the National Academy of Sciences will compare the careers of physicians who received research training through three alternative programs: NIH post-doctoral fellowship training, intramural NIH research and clinical associate programs, and the NIGMS medical scientist training program. Matched samples of graduates from each program will be compared on the basis of medical school employment, faculty rank advancement, publications, honors and grant success.

The Faculty Roster System, initiated in 1965, continues to be a valuable data base, containing information on current appointment, employment history, credentials and training as well as demographic data for all salaried faculty at U.S. medical schools. In addition to supporting AAMC studies of faculty manpower, the system provides medical schools with faculty information for use in the completion of questionnaires for other organizations; for the identification of alumni now serving on faculty at other schools; and for production of special reports.

The Faculty Roster supports a variety of manpower studies, including an annual descriptive study. These studies are funded in part by the National Institutes of Health. In 1979, *Comparison of Characteristics of U.S. Medical School Salaried Faculty in the Past Decade, 1968–1978* was published. The report provides comparison data and summary information on faculty appointment characteristics, educational characteristics, and employment history, it provides various breakdowns by sex and ethnic group.

A new descriptive study deals with changes in the characteristics of newly hired full-time faculty over an eleven year period. As of June 1980 the Faculty Roster contained information for 56,207 faculty; an additional 30,217 records are maintained for "inactive" faculty, individuals who have previously held a faculty appointment.

The Association maintains an index of women and minority faculty, based on the Faculty Roster, to assist medical schools and federal agencies in their affirmative action recruiting efforts. Since January 1980 staff at AAMC have been able to provide, for those faculty members who have consented to release their data, specific information to aid in filling senior positions in medical schools and to assist

in recruiting consultants and members of advisory groups for the National Institutes of Health and other agencies.

The Association's 1979–80 *Report on Medical School Faculty Salaries* was released in January 1980. Compensation data were presented for 116 U.S. medical schools and 29,857 filled full-time faculty positions, 1,459 more than in last year's survey. 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 provide comparison data according to type of school ownership, degree held, and geographic region as well.

Students

Approximately 36,000 applicants filed more than 325,000 applications for the entering class of 1980 in the 126 U.S. medical schools. These numbers represent virtually no change from the previous year. This year there was a slight increase in the number of candidates from minority racial/ethnic backgrounds.

First-year enrollment rose from 16,501 in 1978–79 to 16,930 in 1979–80 while total enrollment went from 62,213 to a record high of 63,800. This increase was the smallest in the past five years and was due primarily to the admission of charter classes at two newly established medical schools and additional places becoming available at other newly developed medical schools.

The number of female medical students reached 16,141, constituting 25.3 percent of total enrollment and continuing the upward trend observed over the last decade. First-year enrollments of female medical students rose from 25.2 to 27.8 percent.

The application process was facilitated by the Early Decision Program and by the American Medical College Application Services. For the 1980–81 first year class, 819 students were accepted at 56 participating medical schools. Since each of these 819 students filed only a single application rather than the average of 9.3 applications, the processing of approximately 6,800 multiple applications was eliminated.

Ninety-six medical schools used AMCAS to process first-year application materials for their 1980–81 entering classes. In addition to collecting and coordinating admissions data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admissions, matriculation, and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Student Affairs Steering Committee.

Beginning this fall the annual study of U.S. applicants will be replaced by a broader annual premedical study. To provide data to health professions advisors, the Advisor Information Service circulates rosters and summaries pertaining to applicants who have authorized the release of personal information. In 1979–80 222 health professions advisors subscribed to this service.

While it is necessary to investigate the application materials of only a small proportion of prospective medical students for suspected irregularities in the admissions process, the number of such investigations rose substantially for students applying to medical school in 1980–81. The average number of such cases had fluctuated around 30 for the past several years. To date, however, the number of potential irregularities for 1980–81 admission has doubled. Attempts by AAMC to refine methods of detection of potential application irregularities continue. A computerized file of confirmed irregularity cases will ensure that applicants exhibiting unethical behavior do not gain unwarranted admission to medical school.

While the number of MCAT tests administered in 1979 represented a 9.2 percent decrease from 1978, the number of examinees sitting for the spring 1980 administration was almost identical to the volume in spring of 1979. Since the spring administration is usually indicative of the number of fall examinees, the decline in examinees may have reached a plateau. The percentage of female examinees continued to increase and now comprises 32 percent of the examinee pool. The trend observed in 1978 which demonstrated an increasing proportion of college graduates and decreasing proportion of college juniors among first-time examinees changed in 1979. While the number of first-time junior examinees declined in 1979 from the previous year, the rate of decline of five percent was considerably lower than the 22 percent decline in the number of first-time college graduate examinees. Further study will

be undertaken of the 1980 examinee group.

During 1979–80 efforts continued to improve the availability and types of financial assistance available to medical students. A Forum on Financing Medical Education was held during the 1979 AAMC Annual Meeting. Members of Congress, Congressional staff and representatives of the Administration met with medical school representatives, heard a presentation of problems and possible solutions, and discussed student financial aid issues. Throughout the winter and spring, bills renewing the Health Professions Educational Assistance Act of 1976 and the Higher Education Amendments of 1976 were carefully monitored. Testimony was presented at each appropriate hearing. An ad hoc Student Assistance Working Group to advise the AAMC Task Force on the Support of Medical Education about financial aid policy met in February to review previous AAMC testimony and recommend criteria for student financial assistance programs. The Higher Education Finance Research Institute at the University of Pennsylvania, under contract to AAMC, developed a computer model for estimating the cost and impact of federal loans to health professionals in the 1980s. The model provides a useful tool for analyzing the effect of various loan policies.

In cooperation with the National Board of Medical Examiners 1,725 U.S. citizens enrolled in foreign medical schools or on official leave of absence were sponsored to take the June 1979 NBME Part I examination and 700 were sponsored to take the September 1979 examination. Of the combined group, 1,985 took the examination and 51 percent passed. This was the last COTRANS sponsorship for the NBME Part I examination.

Commencing in June 1980, a separate examination, developed and administered by the NBME and sponsored by the AAMC and known as the Medical Sciences Knowledge Profile was administered. In this first administration, 2,144 citizens or permanent resident aliens from the United States and Canada registered for the two-day examination. Of those, 90.5 percent reported they were pursuing M.D. degrees; 4.2 percent other health professions degrees; 1.8 percent Ph.D. degrees; and 3.5 percent reported either pursuing a master's or bachelor's degree or no degree at all.

The MSKP examination provides constituent schools of the AAMC a means of assessing knowledge in the medical sciences and in introductory clinical diagnosis for individuals being considered for placement with advanced standing. Each part of the examination is scored on a nine point scale; there is no total score and no designation of pass or fail levels.

As a result of a two-year grant from HEW, more Simulated Minority Admissions Exercise Workshops were held. SMAE, developed by the AAMC in 1974, assists admissions committees to evaluate noncognitive information on nontraditional applicants to medical school. Since September 1978, federal funding has supported thirteen workships for nearly 400 faculty, medical school administrators and premedical advisors. To expand the use of SMAE, individuals in each region have been trained to administer the workshops.

Results of the second national administration of the AAMC's Medical Student Graduation Questionnaire were sent to each medical school graduating student in 1979. The school reports compared the response of all 8,382 graduates who completed the 7-page questionnaire with those of the respondents from each institution. Selected highlights of the 1979 survey were also included in the 1979 *Directory of the National Resident Matching Program* in the form of an "AAMC Graduation Questionnaire Report to the Class of 1980." Results from the more than 10,000 respondents to the 1980 survey were reported to the schools during the summer and to the 1981 seniors in the fall.

The AAMC Universal Application for First Year of Graduate Medical Education, which was developed at the recommendation of the AAMC Task Force on Graduate Medical Education, was widely circulated for review and comment and subsequently revised to accommodate the suggestions received. The universal application will facilitate the process of applying for a first-year residency position by providing a standard form for transmittal of basic information from students to hospital program directors. Copies of the final version of the form have been distributed to teaching hospitals nationwide; plans for its implementation are being developed on the basis of program directors' willingness to accept the universal application.

In 1979–80 the Group on Student Affairs suggested changes in the AAMC recommendations concerning medical school acceptance procedures, also known as the "traffic rules." The adopted changes suggested limits on the amount of tuition deposits and the dates by which they become nonrefundable. The GSA also set up a telephone cascade for quick communications.

The Group on Student Affairs—Minority Affairs Section Coordinating Committee developed an implementation plan for the recommendations of the AAMC Task Force on Minority Student Opportunities in Medicine. The plan focuses on four major areas: prematriculation, matriculation, graduate medical education, and faculty development and was accepted with modifications by the Executive Council in March 1980.

The Women's Liaison Officers again participated in the four regional meetings of the Group on Student Affairs. The program of the Western Region included a panel discussion on the role of women at medical schools in the 1980s.

Institutional Development

In 1972 a program was initiated to strengthen the management of medical schools and academic medical centers. The Management Advancement Program consists of several interdependent parts: an Executive Development Seminar (Phase I), the Institutional Development Seminar (Phase II), and Technical Assistance and Special Programs (Phase III). To date, forty-four seminars have been offered; participants from 125 U.S. and 13 Canadian medical schools as well as 135 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 Executive Development Seminar for senior academic medical center administrators is an intensive week-long seminar on management theory and technique. The follow-up Institutional Development Seminars are designed to facilitate managerial decision-making on broad institutional issues. Each dean who attends selects a group of key individuals from the institution who would need to be involved in the decisions and plans relating to the critical issues under consideration. Five or six such institutional teams meet at an off-site location for several days for plenary sessions on management topics and team analysis and discussion of their own institutional management problems. Each school team is assigned an experienced management consultant who facilitates the work of the group and advises on alternative approaches for dealing with the management issues involved.

During the past year there were three Executive Development Seminars for medical school deans, for teaching hospital directors, chairmen of medicine and service chiefs of affiliated hospitals. In addition, a special seminar for deans was offered on financial management. The Financial Management Seminar reviews the basic principles of sound fiscal management and allows deans to share and discuss common problems and alternative solutions in this increasingly complex and critical area. A special seminar was conducted this past year for women in senior administrative roles in academic medicine. Plans are underway for additional programs for chairmen of pathology, anesthesiology and some of the surgical specialties as well as for a conjoint program for the Group on Business Affairs and the Group on Institutional Planning.

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 the Harvard University Graduate School of Business Administration, the University of Oklahoma College of Business Administration, the Brigham Young University, the University of North Carolina School of Business Administration, and the George Washington University School of Government and Business Administration. Initial financial support for the program came from the Carnegie Corporation of New York and from the Grant Foundation. Funds for MAP implementation and continuation have come primarily from the Robert Wood Johnson Foundation; in addition, conference fees help to meet expenses.

The Management Advancement Program stimulated the interest of program participants

and others for the development of mechanisms that continue access to management information of particular interest to academic medical center administrators. Therefore, in 1976 the Management Education Network was designed to identify, document and transmit management information relevent to medical center settings. With support from the National Library of Medicine *MAP Notes*, an annotated bibliography of the management literature drawn from current periodicals and journals, has been prepared and distributed. Other 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. Several of these products were completed and made available for the first time this year. The final report of the study of academic tenure will be available for distribution shortly. During the course of the tenure study the information developed has been made available to many medical schools concerned with tenure questions.

In addition, 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.

A new area of management policy analysis was undertaken this year to develop the planning principles that might guide institutional decision makers in designing and implementing programs of health information handling for the academic health sciences library, particularly in the context of technological and environmental change. The principal areas of study relate to the library's mission, function, structure and financing; its service objectives and roles; and its administrative relationships to other medical information delivery modalities, both internal and external. The study is supported by the National Library of Medicine and is targeted for completion in 1982.

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

Teaching Hospitals

The Association's teaching hospital activities have been concentrated in four areas during 1979–80: analyzing and responding to proposed federal legislation, evaluating federal regulatory proposals, beginning a study of the characteristics of member hospitals, and collecting and disseminating survey research data.

Early in 1979 H.R. 2222 was introduced to amend the National Labor Relations Act to define interns and residents as employees for purposes of the Act. The bill would have overturned the March 1976 *Cedars-Sinai* decision of the National Labor Relations Board. The Association objected that the bill would alter the fundamental relationship between house staff and faculty from an educational to an employment model and that the educational emphasis of graduate medical education would be replaced by a new emphasis on "wages, hours, and terms and conditions of employment." The Association and its members actively opposed the bill from its introduction. While H.R. 2222 was expeditiously approved by the Subcommittee on Labor-Management Relations and its parent Committee on Education and Labor, it was soundly defeated when brought before the House.

In a related judicial action the full U.S. Court of Appeals for the District of Columbia heard arguments that the NLRB had exceeded its authority in deciding the *Cedars-Sinai* decision to stand, stating "In this case the (National Labor Relations) Board carefully analyzed the facts and reached the conclusion that interns, residents, and clinical fellows are primarily engaged in graduate educational training and that their status is therefore that of students rather than of employees; that the programs in which they participate were designed not for the purpose of meeting the hospital's staffing requirements, but rather to allow the student to develop, in a hospital setting, the clinical judgment and the proficiency in clinical skills necessary to the practice of medicine in the area of his choice. In making this determination the Board acted within its jurisdiction."

Since its inauguration, the Carter Administration has sought legislation limiting allowable hospital revenues. Misleadingly titled as a hospital cost containment bill, the legislation evoked strong opposition from hospitals and their associations. The AAMC worked with its members in testifying against and opposing the Administration's proposal which was considered and defeated by the House.

In opposing legislation mandating a federal regulatory approach to hospital revenue limitations, several members of Congress developed an interest in reducing the rate of increase in hospital revenues by stimulating competitive pricing among hospitals and insurance companies. The Association testified before the Health Subcommittee of the Senate Finance Committee on several proposals to increase hospital competition. While noting that the Association shared the goal of encouraging patients and hospitals to make cost conscious decisions, the AAMC expressed concern that no one had articulated the appropriate limits of competition or the impact of competition on patients, physicians, or hospitals. The AAMC also questioned the impact of a competitive approach on the medical education programs of hospitals, the availability of tertiary care services, the incentive for providing high quality services, and a hospital's ability to care for charity patients.

While the Carter Administration continued to promote hospital revenue limitations, changes in the general economy and local developments in several communities threatened several hospitals with financial insolvency. The Association submitted testimony to the Health Subcommittee of the Ways and Means Committee addressing the financial plight of urban hospitals serving primarily medically indigent and uninsured patients. Noting that these hospitals need long-term solutions which reform

the financing of medical services for the medically indigent and the poor, the AAMC argued that these hospitals also need immediate, external assistance including modifications in Section 223 limitation procedures, Medicare and Medicaid participation in paying hospital bad debts, special project funds to modernize facilities, and special grant programs.

Section 227 of the 1972 Medicare Amendments to the Social Security Act established special provisions for payment of physicians' professional medical and surgical services in teaching hospitals. While then Secretary Califano agreed to delay implementation of Section 227 at the 1978 AAMC Annual Meeting, no legislative action was taken to postpone officially implementation beyond the October 1, 1978 deadline. This year there have been several efforts to pass legislation to delay Section 227. Because federal officials continued to develop draft regulations which would have discriminated against physicians and patients in teaching hospitals, the Association endorsed the repeal of Section 227, which was adopted by the Committee on Interstate and Foreign Commerce.

The Association has also supported an amendment to limit the HHS Secretary's authority to prescribe mandatory federal personnel standards for clinical laboratories, including hospital laboratories. As an alternative to personnel credentials, the Association advocated blind output testing for clinical laboratories.

During the past year, there has been a revived interest in national health insurance legislation. To assess previous Association policy positions which were adopted in a more expansionary economic climate, the AAMC appointed a National Health Insurance Review Committee. The committee's proposals, adopted by the Executive Council, recognized that comprehensive insurance coverage is generally now in force for most Americans. Therefore, the new Association statement advocates expansion and improvement of health insurance in the United States through Medicaid eligibility and coverage reforms, an incentive program to make catastrophic health insurance more widely available, and a commission to certify minimal standards for basic health insurance policies.

Renewal of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), operating under special extensions since 1977, was the focus of legislative activity this year. Passage of renewal legislation came only after months of debate, negotiations, and amendments.

During the Senate and House deliberations, the AAMC called for the extension of certificate of need review requirements to all major medical equipment in excess of $150,000; HSAs to be prohibited from conditioning approval of one health service request on an agreement to develop another health service; HSAs to be permitted to approve the limited introduction of new technologies prior to development of planning guidelines for them; the elimination of grant support to states for development of potentially mandatory programs for decertification of institutional resources and facilities; and the inclusion of a chief executive officer of a tertiary care/referral hospital on HSA and SHCC boards.

In addition, the AAMC specifically urged health planning legislation to include provisions requiring that the dean of a medical school be represented on an HSA board if the health service area contained an accredited school of medicine, and requiring that HSA and state agency reviews consider the effect of proposed services on the clinical needs of health professional training programs and the extent to which the health professions school would have access to the services for training purposes. Both of these provisions appeared in several of the early versions of the legislation this year, but only the second provision was adopted.

In the spring of 1979, HCFA published the final regulations for setting routine service limitations for all cost reporting periods beginning on or after July 1, 1979. A mailgram survey revealed that teaching hospitals would be disproportionately penalized by the new payment limitations. Because of this adverse impact, the Association held a national meeting on Section 223 to allow HCFA to describe the present limitations and exception methodology, to provide HCFA with a sense of the financial devastation the regulations would create for the nation's medical centers, and to allow COTH

members to explain to their Congressional representatives the adverse financial and operational impacts resulting from these limitations.

Subsequently HCFA published a notice that raised the per diem limits and invited public comments on the statistical threshold used to set the limitation. In the Association's comments on this proposed rule, the negative and inequitable impact of HCFA's proposal to use 115 percent of the group mean to set limits was outlined. The AAMC strongly recommended that HCFA return to using the 80th percentile plus 10 percent of the mean for determining a limit in each grouping of hospitals as was done in previous years. As a result of the extensive comments received, HCFA retained the 80th percentile for 1979–80.

When the AAMC Executive Committee met with HEW Secretary Harris to discuss Association concerns with Department actions, specific attention was given to the adverse impact of Medicare Section 223 reimbursement limitations on COTH members. When a subsequent HEW analysis confirmed this adverse impact, HCFA began exploring alternatives to correct this bias.

HCFA suggested an adjustment for reporting years beginning July 1, 1980. Once again, the AAMC surveyed hospitals to assess the regulatory impact and learned that the proposed teaching hospital adjustment did make the limitation approach more equitable. In its comments, therefore, the AAMC emphasized that the methodology proposed in the April 1, 1980 *Federal Register* reduced two of the deficiencies of prior methods by recognizing the indirect costs of medical education on teaching hospitals and by accounting more accurately for the impact of local wages on routine operating costs. Nevertheless, the methodology still fell short of measuring in any meaningful, defensible way the purported sources of concern—inefficiency and the provision of unnecessary services.

In a regulatory proposal related to the Medicare limits on routine services, HCFA proposed an expanded and more heavily quantitative definition of special care units which are not subject to the routine service payment limits. The AAMC strongly recommended that HCFA halt its attempt to define special care units using a physical plant and nursing input criteria. HCFA was urged to prepare regulations which would have the hospital, with PSRO approval, determine special care patients on the basis of their medical needs.

In March 1980 HCFA proposed the Annual Hospital Report as a uniform reporting system for hospitals. The Association and many of its members objected to the proposal on policy and technical grounds. Although the AAMC reiterated its support for uniform hospital reporting, it opposed the proposed AHR system because it was an excessive use of the Secretary's authority, required excessive information, combined reporting and reimbursement, and failed to provide necessary additional revenue for system introduction and maintenance. In lieu of AHR, the AAMC recommended a reporting system using audited financial statements, consolidated cost centers, statistically reclassified entries and sampling procedures, and a more liberalized concept of materiality. Finally, the AAMC recommended data from any uniform reporting system be considered confidential unless necessary for the efficient operation of another government agency and formal, written consent had been obtained from the identified hospitals.

For several years Medicare's practice of offsetting primary care grant funds prior to determining a hospital's Medicare reimbursement has diluted the positive impact of these grants. In 1978 then HEW Secretary Califano promised that this practice would be changed and proposed new regulations. The Association complimented HCFA on the proposed change in policy, recommended that the proposed rule be effective for cost reporting years beginning in 1975, and urged that the present definition for the costs of approved educational activities be left unchanged.

A HCFA final rule proposed a uniform application on July 1, 1980, of regulations governing payments to physicians compensated by or through hospitals on a contractual basis. In commenting, the Association objected to HCFA's failure to use a notice of proposed rulemaking, objected to the short time between the announcement of the policy change and its proposed implementation, and agreed that special care and attention were needed for clinical

pathology services. For clinical pathology, the Association supported as one option language from Senate Report 96-471 which would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on an approved relative value scale "... which takes into consideration such physician's time and effort consistent with the inherent complexity of procedures and services."

The AAMC gave a "mixed review" to proposed regulations affecting the Provider Reimbursement Review Board. The AAMC favored provisions of the proposed regulations which would accelerate review of PRRB cases to the courts and opposed other provisions which would lead to increased control of the PRRB by HCFA, as well as undercut the PRRB's mandate to review HCFA policy.

The AAMC supported a number of the amendments to existing PRRB procedures including expedited judicial review, making "final decisions" of the PRRB reviewable only by the courts, clarifying the deadlines for health care providers to seek judicial review of PRRB decisions, and prohibiting "ex parte" communications during a review of a PRRB decision.

In other comments the Association agreed with a provision that would designate HCFA as the party representing the Medicare program in most PRRB cases. However, the AAMC strongly opposed allowing the HCFA Administrator to continue to be the final appeals authority for PRRB decisions within HHS since the agency would be a party to the PRRB proceedings. The remaining provisions of the proposed regulations were uniformly opposed by the AAMC because they would weaken the PRRB and bring its independence into question.

The Association also commented on the proposed regulations by the Center for Disease Control and HCFA that proposed a uniform set of standards applicable to supervisory technical personnel in clinical laboratories subject to regulation under the Medicare program and the Clinical Laboratory Improvement Act of 1967. The Association challenged the proposition that credentialing of personnel is an effective and reasonable approach to assure the accuracy and reliability of test results. The Association felt that the establishment of a single set of standards for all laboratories failed to consider the special needs of clincial research laboratories. Finally, the AAMC criticized the arbitrary and inflexible qualifications proposed, which it believed would have a negative impact upon the quality of laboratory testing. The AAMC proposed an alternative approach to assuring the quality of a laboratory, including an expanded program of proficiency testing in laboratory certification, limiting the proficiency testing to the most frequently performed tests, and, for certain laboratories, the establishment of standards for full-time laboratory directors and technical supervisors only, certification of the quality of these laboratories by on-site and blind output testing and inspection as needed.

During the year the AAMC commented upon two aspects of the nation's health planning program—draft regulation for national planning goals and revised conditions for approved certificate of need programs. The Association supported the broad, general concepts of the draft national goals; however, it recommended the deletion of a statement which unfairly conditioned the future funding of new health care initiatives on limiting the resources devoted to inpatient care and the insertion of uniform reporting in place of uniform cost accounting as a desired national health planning goal.

The Association submitted comments and recommendations on the proposed regulations governing certificate of need reviews by state health planning and development agencies and health systems agencies. The Association was pleased that the HHS Secretary had followed strictly the substance of the statutory provisions requiring that the criteria for reviews include consideration of the clincial and access needs of health professions training programs, and the special needs and circumstances of those entities providing a substantial proportion of their services and resources to individuals residing outside of their immediate health service areas. The AAMC, however, was particularly concerned about an issue not addressed by the regulations—Congressional intent with regard to the need to review proposed training and research projects, facilities, and medical equipment without a major impact on the availability or delivery of health services in a health service area. The Association noted that Congress spe-

cifically provided that both research and training projects under the Public Health Service Act should not be reviewed by HSAs under the "review and approval of proposed uses of federal funds" responsibility when the training project would not alter health service availability or when the research project would not change the delivery or availability of services to those in an area who are not direct participants in the research. The AAMC called for the exemption of such projects from the CON review process as a more accurate interpretation of legislative intent.

The 1979 COTH Spring Meeting had concluded that methodologies were needed to quantify intensity and educational costs so that teaching hospitals could be classified into homogeneous groups or scaled into continuous distributions. This recommendation was supported by the Executive Council and staff developed a state-of-the-art paper on approaches to quantifying patient intensity and an annotated bibliography on educational costs. Review of this paper was followed by the appointment of an ad hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals charged with guiding the Association's special project on the patient intensity of care in teaching hospitals. The committee has recommended that AAMC monitor and visit case mix researchers, state and federal reimbursement experiments, and developers of management information systems focusing on patient diagnosis; sponsor a workshop on case mix measurement, reimbursement, and management information systems; evaluate the HCFA case mix assumptions; and develop a study of the characteristics and costs of teaching hospitals.

In formulating the plan for a study of the COTH membership, significant questions were raised about the case mix and financial data for the study. Seven hospitals with significant past experience in merging patient-specific clinical and financial data were convened as an advisory panel to the larger committee. It was the consensus that a case mix project should begin with a limited number of hospitals, use the Yale Diagnosis Related Groups, and use charges and "charges adjusted for cost to charge ratios" to compare the costs of cases.

The committee has also approved an 18-month study to develop profiles for a sample of teaching hospitals on case mix, program and services, and financing. A comprehensive description of teaching hospitals will be derived.

In addition to these reports the Association has maintained its program of regular membership reports and surveys. An expanded *COTH Report* is published approximately 10 times a year. The COTH Directory of Education Programs and Services, published annually for 12 years, provides a profile of each COTH member hospital, including selected operational and educational program statistics. The COTH Survey of Housestaff Stipends, Benefits, and Funding publishes information on levels of stipends for house staff. It also provides information on fringe benefits for house staff and on sources and amounts of funding per hospital.

Communications

A variety of publications, news releases, news conferences and personal interviews with representatives of the news media are used by the Association to communciate its views, studies, and reports to its constituents, interested federal representatives, and the general public.

The AAMC initiates or responds to more than 20 news media interviews and requests for information and policy statements each week. In part, this media interaction has been responsible for the editors of *U.S. News and World Report* naming the Association's President as "one of the most influential leaders in the health field" for the fourth consecutive year. The magazine editors base their assessment on the views of journalists, Capitol Hill aides, members of Congress and others.

The major vehicle used by the Association to inform its constituents is the President's *Weekly Activities Report.* This publication, 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 research, and health care.

The *Journal of Medical Education* in fiscal 1980 published 1,039 pages of editorial material in the regular monthly issues, compared with 1,015 pages the previous year. The published material included a total of 178 papers (86 regular articles, 83 Communications, and 9 Briefs), compared with 164 papers in fiscal 1979. 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 1979–80 totaled 423, compared with 450 and 429 the previous two years. Of the 423 articles received in 1979–80, 140 were accepted for publication, 211 were rejected, 16 were withdrawn, and 56 were pending as the year ended. Monthly circulation averaged 6,400.

During the year special issues were devoted to cost containment, MCAT, continuing medical education, and the AAMC Annual Meeting. An AAMC study, "Continuing Education of Physicians: Conclusions and Recommendations," and the Association's annual report and annual meeting program were published as supplements.

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. Newsletters include the *COTH Report* with a monthly circulation of 2,600; the *OSR Report*, circulated twice a year to medical students, *STAR* (Student Affairs Reporter), which is printed twice a year and has a circulation of 800; and the *Council of Academic Societies Brief*, which is published quarterly 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, installed in September 1976, 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 is in progress on a unified system to monitor students from their pre-medical years through the application process, medical school, and into the first years of their post-M.D. experience. When completed, 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 schools 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. Finally, the AMCAS system is used for regular descriptive studies of medical school applicants as well as more focused, issue-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 and questionnaire responses 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 on-line access and update capability to the information. Data in the Faculty Roster system are periodically reported back to the medical schools in summary fashion, enabling the schools to obtain an organized, systematic profile of their faculty. The Faculty Salary Survey system amasses the 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 respository 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 database supported by a computer 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 16,000 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 for input on-line editing of the data and generates reports that identify errors and inconsistencies in the data on the questionnaires and compares 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 Housestaff Policy Survey, the Income and Expense Survey for University Owned Hospitals, and the Executive Salary Survey. These surveys 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 role of the biomedical researcher 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 availabale information resources to focus on these and other areas of importance to academic medicine.

AAMC Membership

Type	1978-79	1979-80
Institutional	113	116
Provisional Institutional	13	10
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	17	18
Academic Societies	67	69
Teaching Hospitals	418	423
Corresponding	30	40
Individual	1,660	1,384
Distinguished Service	42	48
Emeritus	63	62
Contributing	6	15
Sustaining	15	14

Treasurer's Report

The Association's Audit Committee met on September 15, 1980 and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1980. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 25, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $8,925,618. Of that amount $7,445,828 (83%) originated from general fund sources; $348,201 (4%) from foundation grants; $1,131,589 (13%) from federal government reimbursement contracts.

Expenses for the year totaled $8,412,691 of which $6,575,856 (78%) was chargeable to the continuing activities of the Association; $458,785 (5%) to foundation grants; $1,131,589 (13%) to federal cost reimbursement contracts; $246,461 (3%) to Council designated reserves. Investment in fixed assets (net of depreciation) increased $72,564 to $749,935.

Balances in funds restricted by the grantor decreased $186 to $370,786. After making provision for reserves in the amount of $570,000 principally for equipment acquisition and replacement and MCAT and AMCAS development, unrestricted funds available for general purposes decreased $34,982 to $6,695,615, an amount equal to 80% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100% 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, 1980

ASSETS		
Cash		$ 205,501
Investments		
Certificates of Deposit		9,842,099
Accounts Receivable		1,104,381
Deposits and Prepaid Items		43,440
Equipment (Net of Depreciation)		749,935
Total Assets		$11,945,356
LIABILITIES AND FUND BALANCES		
Liabilities		
Accounts Payable		$ 672,544
Deferred Income		1,619,952
Fund Balances		
Funds Restricted by Grantor for Special Purposes		370,786
General Funds		
Funds Restricted for Plant Investment	296,856	
Funds Restricted by Executive Council for Special Purposes	1,539,668	
Investment in Fixed Assets	749,935	
General Purposes Fund	6,695,615	9,282,074
Total Liabilities and Fund Balances		$11,945,356

Association of American Medical Colleges
Operating Statement
Fiscal Year Ended June 30, 1980

SOURCE OF FUNDS	
Income	
Dues and Service Fees from Members	$2,191,419
Grants Restricted by Grantor	348,201
Cost Reimbursement Contracts	1,131,589
Special Services	3,326,493
Journal of Medical Education	81,352
Other Publications	289,939
Sundry (Interest $1,258,405)	1,556,625
Total Income	$8,925,618
Reserve for Special Legal Contingencies	136,046
Reserve for CAS Services Program	1,074
Reserve for Special Studies	2,443
Reserve for Computer Equipment	-0-
Reserve for Minority Programs	62,151
Reserve for Patient Intensity Program	18,024
Reserve for Personal Assessment	26,723
Total Source of Funds	$9,172,079
USE OF FUNDS	
Operating Expenses	
Salaries and Wages	$3,648,038
Staff Benefits	544,643
Supplies and Services	3,318,567
Provision for Depreciation	152,360
Travel and Meetings	638,083
Provision for Contract Adjustments	111,000
Total Expenses	$8,412,691
Increase in Investment in Fixed Assets (Net of Depreciation)	72,564
Transfer to Executive Council Reserved Funds for Special Programs	570,000
Reserve for Replacement of Equipment	151,992
Increase in Restricted Fund Balances (decrease)	(186)
Increase in General Purposes Fund (decrease)	(34,982)
Total Use of Funds	$9,172,079

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