

Association of American Medical Colleges
Annual Meeting
and
Annual Report
1982

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Chairman's Address

Rain Dance

Thomas K. Oliver, Jr., M.D.

I'm sure that every person who has been in this position has asked himself over and over, "What am I going to say?" Since I consider myself to be a pragmatist, I have decided to do what is most natural for me—to discuss with you some conclusions that I have reached during nearly a decade with the Association of American Medical Colleges. First, I will discuss medical manpower from the perspective of one of the Association's representatives to the former Liaison Committee on Graduate Medical Education and a member and the first chairman of the successor organization, the Accreditation Council on Graduate Medical Education; and second, I will present some views on manpower and research support which I have developed during this year as chairman of the Association. Many of you know I spent the period from mid-January to mid-May of this year in Washington trying to convince the Reagan Administration and the Congress of the wisdom of the three highest priorities of the AAMC, namely that there should be financial support for medical students and that support of research and research training should be maintained at stable levels.

A few years ago the Graduate Medical Education National Advisory Committee (GMENAC) announced its findings and

concluded that we were educating too many physicians and that by 1990 there would be a surplus in almost all subspecialties. It recommended that there should be a 10 percent reduction in the number of students entering medical school by 1984. Although there has been considerable criticism of the methodology used in reaching conclusions regarding the number of specialists needed, the GMENAC report nonetheless represents the best effort that has been made to date and surely deserves our thoughtful consideration. And what have our medical schools done during and following that report? They have steadily increased the numbers of students in medical school to the extent that there were more than 16,000 graduates in 1982. It should be noted that for the entering class in 1982, that is, the class of 1986, there were actually 77 fewer students than in 1981, the first decrease in more than two decades. However, there is little reason to believe that medical student enrollments are actually leveling off, since there are a number of new schools that have not reached their full enrollment goals that have been approved by the Liaison Committee on Medical Education. There are now 127 medical schools that have been accredited by the LCME, the last a new school given provisional approval in Macon, Georgia, recently. Using present trends, it appears that the GMENAC was right on target with respect to the aggregate. By 1990 it is estimated that about 466,000 physicians will be required, whereas the supply will be from

This paper was delivered at the November 9, 1982, plenary session of the Annual Meeting of the Association of American Medical Colleges, Washington, D.C.

Dr. Oliver, chairman of the Department of Pediatrics at the University of Pittsburgh School of Medicine, was the 1981-82 chairman of the AAMC.

506,000 to 541,000, depending on what assumptions are used. While there appears to be little, if any, evidence of leveling off in the number of students entering medical education—and let me remind you that that is a long pipeline, one lasting at least seven years—there are major changes going on with respect to the accreditation of programs in graduate medical education. This is the responsibility of the ACGME and the 23 residency review committees (RRCs) that review programs and advise the ACGME regarding accreditation. In 1982, there were slightly more than 18,000 accredited positions in graduate medical education, excluding positions available in the armed forces. The ratio of positions to graduates in 1982 was 1.12 to 1. However, this seeming excess of nearly 2,000 available positions to candidates is not as real as it appears. First, there are a number of unfilled positions in certain specialties. In addition, there are a substantial number of positions in programs to which American graduates either do not apply at all or apply in very, very small numbers. These are programs that are filled almost exclusively by foreign medical graduates, either aliens or U.S. citizens. Taking into account these figures, the ratio of positions in graduate medical education in accredited programs to the number of U.S. graduates in 1982 was essentially 1 to 1. While little has been done to date to stabilize or decrease the number of students entering the pool, the same cannot be said of the residency review committees and the ACGME. Increasingly the RRCs are revising and making more rigid and explicit their special requirements for accreditation. There is little question that the number of accredited programs in graduate medical education will decrease with the result that the aggregate number of available positions soon will be substantially exceeded by the supply of medical school graduates. This will have obvious

implications on career decision-making. As many of you know, the ACGME has also taken action to assure that graduates of non-LCME accredited medical schools, both aliens and U.S. citizens, be required to pass a written examination equivalent to Parts I and II of the examinations of the National Board of Medical Examiners. At the present time, alien FMGs must pass a more rigorous Visa Qualifying Examination if they are seeking an exchange student visa, while U.S. citizens who are foreign medical graduates need to pass only the ECFMG examination and "fifth pathway" students need no examination at all. All of these students will be treated alike by having to pass a new cognitive examination which will be put in place in July 1984. The ACGME has also recommended that there be a feasibility study for the development of a practical assessment of basic clinical skills which these students would also have to pass prior to entry into an accredited program of graduate medical education. In summary, the committees responsible for accreditation of graduate medical education are clearly moving in the direction of more carefully defining quality, even at the expense of quantity.

Let me now address what can be done with the supply side of this issue, that is, the number of medical students and the concern for an excess in the aggregate number of physicians. First of all, it must be absolutely clear that accrediting bodies, whether for undergraduate or graduate medical education, cannot control the number of positions. The responsibility of the accrediting bodies is to establish standards which must be met for accreditation. If they are met, the numbers are justified. If they are not met, the programs should either be reduced in size or be discontinued. It is my view that the LCME should follow the lead of the ACGME and develop more rigorous standards for accred-

itation. This is more difficult to do than the development of standards for a specialty in graduate medical education, but I believe it is possible. For example, studies conducted by both the AAMC and the Institute of Medicine have identified the requisite resources necessary for the general education of a physician. These include such things as physical resources, laboratory space, the numbers of patients (and beds), and the availability of residents for teaching. While the purpose of these studies was to determine the cost of educating the general physician, they were based to a substantial extent on requisite resources and hence could be used for standard setting. Another possible measure of quality that might be considered includes evidence of research productivity by the faculty as reflected by the size of the research budget compared with the total budget or by the number of peer-reviewed articles. Still another might be the outcome measures of the graduates ranging from the success rate in first choice for residency to the passing rate of external examinations. Let me be quite clear about what I am proposing. The LCME is not "them"; it is us. And all of us in medicine have the responsibility to join the dialogue to establish reasonable, fair, and explicit standards for the general education of the physician.

I would like now to focus on another manpower issue of increasing concern, and I refer to the rising indebtedness incurred by most medical students and the overt decision of the Reagan Administration to get the government out of the long-standing policy of providing some financial assistance to medical students. It is this administration's policy to reduce the National Health Service Corps sharply, essentially to eliminate funds for individuals with exceptional financial need, to limit the Health Professions Student Loan Program for most medical schools and medi-

cal students, and to eliminate the Guaranteed Student Loan Program for all graduate students, including medical students. The only subsidized student loan program which the administration has left untouched is entry into the armed services. The only major nonsubsidized federal loan program proposed by the current administration is the Health Education Assistance Loan Program (HEAL). In this program, interest rates are oppressive and accrue in compound fashion, although repayment of the loan is deferrable until completion of three years of residency. A limit of \$80 million has been placed by the administration for the HEAL program for fiscal year 1983, even though substantially more was borrowed in fiscal year 1982, largely because it frequently is the only available loan resource. We are urging the Congress to make \$200 million available. Let me cite a specific example of the potential indebtedness and what this might mean to medical students. For the class of 1986 of the University of Pittsburgh School of Medicine, that is, the students who began medical school in September 1982, it is estimated that the cost for medical education will be \$20,000 each year, or \$80,000 altogether. It is estimated that approximately \$30,000 of this will be paid by the student or his family but that he or she will have to borrow \$50,000. If the student who enters medical school has to borrow \$50,000 exclusively from the HEAL program, not an unlikely outcome under current administration policy, the accumulated indebtedness would be approximately \$360,000 over a 10-year period, or \$36,000 a year. In my field of pediatrics, individuals who enter practice after their three core years of residency training may expect an income of perhaps \$50,000 a year. If \$36,000 has to come off the top coupled with the overhead of operating an office, it is clear to me that many graduates simply will be unable to

afford to enter pediatrics or other primary care specialties. They will be forced to choose more lucrative specialties. It is equally unlikely that they will choose careers in academic medicine or careers in basic or clinical research. It seems evident that we are on the edge of creating a new elitism for those entering medical school, a financial elitism instead of an academic elitism.

Let me now turn to the issue of research and research support and the clear signal of this administration to change the longstanding role of the government as the patron of science. Several years ago, in an effort to provide some stability to the research enterprise of the National Institutes of Health (NIH), it was suggested that there ought to be funding for approximately 5,000 new and competing individual initiated research grants each year. In 1982 that budgeted number was 4,741. For fiscal 1983 the administration budgeted for 4,100 new grants, a 13 percent reduction, and this was achieved only by pumping in money where the government had no ethical right to do so, by declaring that indirect costs to institutions or universities would be paid at 90 percent of agreed-upon levels. Indirect costs are true costs. They are the costs to the university or the institution for doing research, and someone has to pay them. No matter how carefully an institution budgeted its indirect costs, it could only recover 90 percent of these costs by the policy as established by the administration. Repeated attempts by a number of us have failed to convince either the director of the NIH, the Assistant Secretary for Health, or the Secretary for Health and Human Services to change this policy. Unless additional funds are appropriated by the Congress, the only choices left to universities and to other institutions supporting research are to increase tuition, to charge the investigator from his direct cost budget, or to get out

of research entirely. The outcome of this policy for fiscal 1983 will remain in doubt until the Congress acts. For the future, we have recommended to officials in the administration that representatives of the appropriate governmental agencies, as well as representatives of medical school faculties and university presidents, begin at once to plan how to control sensibly the increasing part of the health research budget that goes to indirect costs. There are ways of doing this, but it should be done prospectively and with broad discussion.

There is another aspect of the administration's proposed research budget which is of even greater concern than the reduction to 4,100 of new and competing research projects and that is the number of grants which will not be funded even though they have been approved by the review process of study sections and subsequently by institute councils. Ideas generated by our faculties which successfully pass peer review should have a reasonable chance of being awarded. This is not the case in the administration's budget for 1983. In 1979 approximately 45 percent of approved research projects were funded. In fiscal year 1983 it will be approximately 21 percent. Thus, only one project in five which have been reviewed and approved by academic peers is destined to be funded if the administration's budget prevails. The impact of this policy on students considering research careers, particularly when coupled with the projected indebtedness, makes it clear to me why there will be a significant graying of our faculties. In 1980 approximately 50 percent of our faculties were less than 45 years old. If the present trends continue, it is estimated that the number will be approximately 25 percent by 1990. The young are both more energetic and brighter than we are, and the implications of aging on the quality and the quantity of research and education

seem clear. What can be done about this?

It seems to me that there are several possibilities. One is to establish ties with industry as a number of our universities have done. Another is to use the private sector in new and imaginative ways. As an example, Dr. Ralph Feigin of Baylor University and the current president of the Society for Pediatric Research will announce at the annual meeting of the society next spring an exciting new program which is focused on involving the private sector in support of young, promising investigators in pediatric research. Another approach which I have formulated is a loan-forgiveness proposal for individuals committed to a career in academic medicine. I have received enthusiastic responses from the staffs of both the Senate and House health authorization committees for the proposal. Although the details have not been worked out, the idea is that physicians who have completed a minimum of two years of fellowship training and a minimum of one year of laboratory research and who have then been recruited by a university in the tenure stream would have their federal loans forgiven by 25 percent for each year that they remain on the faculty. Let me emphasize that two barriers would have to be passed before an individual would qualify for loan forgiveness. There would have to be certification that such a physician indeed did spend a minimum of a year in research training as contrasted to clinical training, and, secondly, there would have to be certification by the university that he was brought on the faculty after completion of fellowship training as a member in the tenure stream. It is estimated that the cost of this program would be modest. Its purpose is to attract students who are seriously inter-

ested in a career in biomedical research.

Now, at last, an explanation of the title of this address: Rain Dance. During my stay in Washington, at a meeting of the AAMC senior staff, I was asked by John Cooper what I intended to accomplish that particular week. I told him of my plans to meet with the staff of several congressmen, to meet with other congressmen directly, and of testimony I was giving before a subcommittee. John's response was, "Ah hah, I see you're going to do your rain dance." And to a certain extent, that's what I seemed to have done in those four months in Washington. I hooped and hollered and postured. And sometimes it rained and sometimes it didn't.

But what I've learned is that it is extraordinarily important for us to do our rain dances. This association has a first-class staff with excellent relationships with policy-makers in the administration and on Capitol Hill. But we must not limit these contacts to the staff. If we believe in the issues and priorities established by the association, it is incumbent upon us to argue for them. We don't all have to come to Washington to do this. Congressmen love to return to their home districts—they do it a lot—and it's easy to arrange meetings there. And in contrast to many other issues the Congress must listen to, ours are not nearly so self-serving. Surely qualified students should not be denied the opportunity of a medical career for financial reasons. And surely career choices should not be dictated by indebtedness. And surely the public has the right to expect for the future the continuation of high quality health care it now receives, and this can only be assured by the maintenance of the biomedical and behavioral research enterprise. We must continue the fight.

The Ninety-Third Annual Meeting

Washington Hilton Hotel, Washington, D.C., November 6-11, 1982

Theme: Academic Values in a Changing Environment

Program Outlines

PLENARY SESSION

November 8

ACADEMIC VALUES IN A CHANGING ENVIRONMENT

Presiding: Thomas K. Oliver, Jr., M.D.

Social Climate of the 1980s and Implications for Medical Delivery Systems
Florence Skelly

The Changing Economic Environment
R. T. McNamar

The Social Determinants of Political Change
Alan J. Pifer

Sustaining Human Values
William Raspberry

November 9

Presiding: Steven C. Beering, M.D.

Presentation of AAMC Research and Flexner Awards

Preservation and Discovery: The Research University

Hanna H. Gray, Ph.D.

Alan Gregg Memorial Lecture:

Can an Invisible Hand Palpate the Carotid Pulse?

Sherman M. Mellinkoff, M.D.

Chairman's Address:

Rain Dance

Thomas K. Oliver, Jr., M.D.

SPECIAL GENERAL SESSION

November 9

GERIATRICS AND MEDICAL EDUCATION

Moderator: Richard Janeway, M.D.

Keynote Speaker:

The Geriatric Challenge to Medical Schools and Teaching Hospitals
Robert N. Butler, M.D.

Panel: William H. Gurtner

Joseph E. Johnson, III, M.D.

John Rowe, M.D.

ACADEMIC MEDICAL CENTERS CONFRONT THE INFORMATION AGE

November 10

REFLECTIONS ON THE AAMC REPORT:
THE MANAGEMENT OF ACADEMIC INFORMATION

Introduction

John A. D. Cooper, M.D.

Academic Information Management for the 1980s: The AAMC Report
John A. D. Cooper, M.D.

The National Library of Medicine's Commitment to Excellence in Academic Information Management
Martin M. Cummings, M.D.

Academic Information Management and the Medical Education Continuum
Cyril O. Houle, Ph.D.

The Role of Libraries in the Teaching Hospital

Donald A. Lackey

Management of Intellectual Resources: Challenges for the 1980s
M. Roy Schwarz, M.D.

Summary

John A. D. Cooper, M.D.

COUNCIL OF ACADEMIC SOCIETIES**November 7****CAS PLENARY SESSION**

The Enigmatic Future and Tumultuous
Past of Medical Education
Stanley J. Reiser, M.D.

CAS/OSR PLENARY SESSION

General Professional Education of the
Physician Project: A Student/Faculty Collo-
quy

Working Group on Fundamental Skills
Victor R. Neufeld, M.D.

Working Group on Essential Knowledge
John A. Gronvall, M.D.

Working Group on Personal Qualities,
Values and Attitudes
Robert L. Kellogg, Ph.D.

CAS/OSR Discussion Groups**GE November 8**

Business Meeting
Presiding: David M. Brown, M.D.

108 COUNCIL OF DEANS**November 7**

Special Session with the Group of Medical
Education on Continuing Medical
Education (See GME section of this program.)

November 8

Business Meeting
Chairman: William H. Luginbuhl, M.D.

COUNCIL OF TEACHING HOSPITALS**November 8**

Business Meeting
Presiding: Mitchell T. Rabkin, M.D.

General Session
Presiding: Mark S. Levitan

Health Care Coalitions: Trustees in a New
Role or Business as Usual?

Willis B. Goldbeck
Irving W. Rabb

GSA/MINORITY AFFAIRS SECTION**November 7**

Minority Student Medical Career
Awareness Workshop

GME/GSA Special Session
on the MCAT

November 8

Student Financial Assistance: Status
of Federal Programs

Regional Meetings

Central
Northeast
Western
Southern

Business Meeting

The Plight and Promise of Minority
Medical Colleges
David Satcher, M.D., Ph.D.

Analysis of Minority Medical Student
Performance at Two Medical Schools
Alonzo Atencio, Ph.D.
Evelyn McCarthy

Minority Physician Distribution
Stephen Keith, M.D.

Innovations in Student Financing**MINORITY AFFAIRS PROGRAM****November 9**

Minorities in Medicine
George S. McGovern

ORGANIZATION OF STUDENT REPRESENTATIVES**November 5****Business Meeting****Regional Meetings**

Southern
Northeast
Western
Central

OSR Program

'Toto, I've got a feeling we're not in
Kansas anymore'—Nuclear Weapons,

Denial Psychology and Physicians' Responsibilities

Moderator: Paul Organ, M.D.

Speakers: Bruce B. Dan, M.D.
H. Jack Geiger, M.D.
Tony Robbins, M.D.

November 6

Business Meeting

Discussion Sessions

New Premises and New Tools in Medical Education

Lawrence Weed, M.D.

Recreating the Joy of Medicine

John-Henry Pfifferling, Ph.D.

Issues Identification Session

Small Group Discussions

Issues Assessment Session

Small Group Discussions

OSR Reception

November 7

Candidate for OSR Office Session

Business Meeting

Joint OSR/CAS Program

Regional Meetings

Western

Northeast

Central

Southern

November 8

Discussion Sessions

A Seminar for Third and Fourth Year Medical Students: How To Retain Your Humanism in the Face of the Technologic Explosion

Robert Lang, M.D.

Alan Kliger, M.D.

Healthy Medical Students: Creating Self-Help Programs

Joel Elkes, M.D.

Leah Dickstein, M.D.

WOMEN IN MEDICINE

November 7

SYMPOSIUM—LEADERSHIP: ROLES, RESPONSIBILITIES AND RISKS

Moderator: Judith Frank, M.D.

Keynote Speakers:

Charles Seashore, Ph.D.

Edith Whitfield Seashore

GENERAL SESSION: THE CHANGING ENVIRONMENT: WHAT'S AHEAD FOR WOMEN

Moderator: Marion Nestle, Ph.D.

Graduate Medical Education

Spencer Foreman, M.D.

Academic Medicine

Leah M. Lowenstein, M.D., D.Phil.

Medical Practice

Alvin Tarlov, M.D.

Reception

November 8

Regional Meetings

Northeast

Central

Western

Southern

A TALE OF O

A 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.

Discussion Leader: Dorothy Brinsfield, M.D.

DAUGHTERS OF SCIENCE

This slide-tape show describes the Oral History Project on Women in Medicine at The Medical College of Pennsylvania. The show documents briefly the history of women physicians and describes the oral history process and features biographical sketches of several of the interviewees.

Discussion Leader: Eva Ray, Ph.D.

November 9

Women's Liaison Officers' Luncheon

The Physician As Writer

BIL- John H. Stone, III, M.D.

DATA BASES IN ACADEMIC MEDICINE**November 9**

ON- Several schools have established student, faculty or institutional data bases that employ the power and versatility of modern computers to serve a variety of important functions. This informal session provided occasion for designers, managers, and users of these data bases to exchange ideas about issues of mutual interest. A portion of the session was set aside to consider establishing a standing affiliation of individuals with interest in data bases.

Moderator: Charles Friedman, Ph.D.

Panel: Paul Jolly, Ph.D.

Ronal Nicholas

Christel Woodward, Ph.D.

David Yens, Ph.D.

FACULTY ROSTER SYSTEM**November 8 and 9**

The Faculty Roster System is a computer-based data storage and retrieval system containing biographical and education data on U.S. medical school faculty. Annual meeting participants were invited to stop by and learn about this AAMC system. Special reports available to the medical schools were described, and questions regarding utilization of the data were answered.

INSTITUTIONAL PROFILE SYSTEM**November 8 and 9**

The AAMC Institutional Profile System is a computer-based data storage, retrieval, and analysis system containing many variables on each U.S. medical school. Annual meeting participants were invited to visit to learn about this data service.

GROUP ON BUSINESS AFFAIRS**November 8****Regional Meetings**

Midwest-Great Plains

Northeast

South

West

GBA NATIONAL PROGRAM—TENURE, RETRENCHMENT, AND THE REALLOCATION OF RESOURCES

Welcoming Remarks

Robert B. Price

Program Introduction

David J. Bachrach

The Paradox of Academic Tenure:

Less for More

Speaker:

Amber B. Jones

Legal Issues Pertaining to Tenure**Speaker:**

John Huffman

Dealing with Tenure**Topic Reactors**

Robert E. Reed, M.D.

Kenneth I. Shine, M.D.

Edward A. Mearns, Jr.

Paul T. McLouglin

November 9**CARROLL MEMORIAL LECTURE****Speaker:**

John A. Gronvall, M.D.

GBA National Business Meeting

Presiding: Robert B. Price

GBA NATIONAL PROGRAM CONTINUED—TENURE, RETRENCHMENT, AND THE REALLOCATION OF RESOURCES

Modifying Faculty Policies in a Changing Environment—A Case Presentation**Speaker:**

Edward J. Stemmler, M.D.

The Business Officer's Role in Managing the Process of Program Retrenchment and Faculty Downsizing

Panel Discussion

Moderator: E. Alun Harris, Ph.D.

Reactors

Gregory F. Handlir

Bernard McGinty

Joseph L. Preissig

Exercise and Its Effect on Job Performance

Speaker:

George Sheehan, M.D.

GROUP ON INSTITUTIONAL PLANNING

November 7

EXTERNAL FORCES RESHAPING THE ACADEMIC MEDICAL CENTER

Welcoming Remarks

John A. D. Cooper, M.D.

The Foundations

Leighton E. Cluff, M.D.

The Demography of Students

Albert P. Williams, Ph.D.

The Economy

Richard H. Egdahl, M.D., Ph.D.

The Competition

C. Rollins Hanlon, M.D.

The University

Lloyd H. Elliott, Ed.D.

Discussion

November 8

Business Meeting

David R. Perry, Chairperson

Regional Meetings

GROUP ON STUDENT AFFAIRS

November 8

Student Financial Assistance: Status of Federal Programs

Moderator: John F. Walters

Report from the Department of Health and Human Services

Thomas D. Hatch

Report from the Department of Education
James Moore

Innovations in Student Financing

Moderator: Cheryl Wilkes

Problems and Prospects: Filling the Gap in Student Aid

Lawrence E. Gladioux

The Tax Exempt Bond Approach at Dartmouth Medical School

Frances Hall

A Student Employment Strategy at Medical College of Georgia

Joseph P. Bailey, Jr., M.D.

Fairfield Goodale, M.D.

November 9

Business Meeting

Chairman: Robert I. Keimowitz, M.D.

November 10

Plenary Session

Combined Session with the Group on Medical Education

COMBINING FORCES TO SURVIVE IN THE 80s

Moderator: Robert I. Keimowitz, M.D.

Perspectives:

Financial Need: A Barrier To Admission

John I. Sandson, M.D.

Student Indebtedness, Specialty Choice and Residency Availability

Edward J. Lennon, M.D.

Curriculum Change and Management in the Context of the Eighties

L. Thompson Bowles, M.D., Ph.D.

Economic Pressures on Faculty Teaching Roles

Daniel X. Freedman, M.D.

Small Group Discussions organized around each of the four themes.

GROUP ON PUBLIC AFFAIRS

November 8

INDUSTRY AND THE ACADEMIC MEDICAL CENTER

Moderator: Dallas Mackey

Speakers: Julius R. Krevans, M.D.

Jack B. McConnell, M.D.

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AWARDS NOMINEE PRESENTATIONS

Moderator: Shirley Bonnem

November 9

AWARDS LUNCHEON

Moderator: Bill Glance

Speaker: William L. Green

Presentation of Awards:

Steven C. Beering, M.D.

THE PUBLIC OFFICIAL AS A PATIENT: THE RIGHT TO PRIVACY OR NOT?

Moderator: Lou Graff

Speakers:

Lawrence K. Altman, M.D.

Roland Wussow

GPA Business Meeting

November 10

DISCUSSION ABOUT MARKETING

Moderator: John Milkereit

Speakers:

Roberta Clark, Ph.D.

Robert M. Cunningham, Jr.

ROUNDTABLE DISCUSSIONS

Classification of Research: The Public Response

Discussion Leader: Lillian Blacker

Medical Research Awareness

Discussion Leader: Glenda Rosenthal

Patient Dumping: How Do You Communicate the Issue?

Discussion Leader: John Turck

Cable and Public Broadcasting

Discussion Leader: Dean Borg

Getting National Media to Your Institution

Discussion Leader: Dan Forbusch

Problems, Problems, Problems

Discussion Leader: Carolyn Tinker

Evaluating Your PR Program

Discussion Leader: Ruth Jacobowitz

Starting Up a New Publication

Discussion Leaders: Mae Rudolph

Sonja Noring

Determining Your Priorities and Setting Institutional Goals

Discussion Leader: Dallas Mackey

Coordinating/Competing with United Way

Discussion Leader: William Fissinger

Fund Raising from Doctors for Doctors

Discussion Leader: Seymour Alpert, M.D.

What Do You Do Between Campaigns?

Discussion Leader: Rusty Brink

The Role of Professional Counsel in Development

Discussion Leader: Gene Hunckler

How Can Alumni Understanding and Support be Cultivated?

Discussion Leader: Muriel Sawyer

Informing Your Constituencies about Adverse Incidents

Discussion Leader: Perry Culver

Are House Officers Alumni and How Do You Bring Them Into the Fold?

Discussion Leader: Una Creditor

GROUP ON MEDICAL EDUCATION

November 7

GME/GSA Special MCAT Session

USING THE MCAT: A REVIEW OF TWO ISSUES

Moderator: Robert L. Beran, Ph.D.

A Re-Examination of the Relevance of MCAT Science Topics After Five Years

Sandra R. Wilson, Ph.D.

Interpreting Repeat Scores and Those Influenced by Commercial Review Courses: Five Years of Experience

Robert F. Jones, Ph.D.

COD/GME SPECIAL CME SESSION

PROFESSIONAL RELATIONS

Moderator: L. Thompson Bowles, M.D.

The Relationship of the Medical School to the Medical Profession

Richard Janeway, M.D.

Continuing Medical Education as a Link of the Medical School to the Medical Profession

John N. Lein, M.D.

Cementing the Relationship Between Profes-

sional Community and Medical School
Through Educational Programs:
The Example of Geriatric Medicine
William R. Hazzard, M.D.

November 8

GME NATIONAL MEETING

The meeting included reports on the AAMC Study of the General Professional Education of the Physician by Dr. Victor Neufeld, the AAMC Clinical Evaluation Project by Dr. Xenia Tonesk, and the GME TRP on "Fifth Pathway Programs" by Dr. Winfield Scott, Panel Chairman.

GME/CME SPECIAL GROUP DISCUSSION

Review and discussion of an AAMC proposal to undertake a CME Development Project in Geriatrics.

Regional Meetings

Northeast
Southern
Central
Western

November 9

Innovations in Medical Education Exhibits

Small Group Discussions

CULTIVATING A SCHOLARLY APPROACH TO MEDICINE

Moderator: Alan Goldfien, M.D.

Panel: Robert E. Anderson, M.D.
Brian Haynes, M.D.
Robert B. Layzer, M.D.
Victor Neufeld, M.D.

CLINICAL ELECTIVES IN THE PRECLINICAL YEARS

Moderator: Arthur Kaufman, M.D.

Panel: Philip Sloane, M.D.
Ellen Tabek

SELECTION AND STANDARDIZATION OF CLINICAL OFF-SITE TEACHING

Moderator: Murray M. Kappelman, M.D.

Panel: Russell R. Moores, M.D.
Carl Rosengart, M.D.

TEACHING OF HEALTH PROMOTION

Moderator: David L. Rabin, M.D.

Panel: Steve Jonas, M.D.
Billy Philips, Ph.D.
Carl Tyler, M.D.

COMPUTER LITERACY IN MEDICINE

Moderator: Donald A. B. Lindberg, M.D.

Panel: John Anderson, M.D.
Richard Friedman, M.D.
Allan H. Levy, M.D.

POLITICAL, SOCIAL AND ECONOMIC ISSUES DRIVING MEDICAL EDUCATION

Moderator: Marjorie P. Wilson, M.D.

Panel: Daniel D. Federman, M.D.
Carl J. Schramm, Ph.D., J.D.
Virginia V. Weldon, M.D.

EVALUATION OF RESIDENT COMPETENCE

Moderator: Steven P. Shelov, M.D.

Panel: Daniel Bernstein, M.D.
Lila Croen
Neil Whitman, Ed.D.
Reed Williams, Ph.D.
Rose Yunker, Ph.D.

INCREASING STUDENT'S DESIRE FOR LEARNING THE PROBLEM-BASED APPROACH

Moderator: S. Scott Obenshain, M.D.

Panel: Bahman Joorabchi, M.D.
Douglas Waugh, M.D.

NEW PERSPECTIVES IN LEARNING THE BASIC SCIENCES

Moderator: Parker A. Small, M.D.

Panel: L. Richard Coulson, Ph.D.
Norman F. White, M.D.C.M.,
D. Psych.

WHAT CAN UNDERGRADUATE MEDICAL EDUCATION LEARN FROM CME?

Moderator: Norman S. Stearns, M.D.

Panel: John Jones, M.D.
Thomas C. Meyer, M.D.
Ed Walker

EXPLORING THE ROLES OF QUANTITATIVE AND QUALITATIVE RESEARCH

Moderator: Paul E. Mazmanian, Ph.D.

Panel: Robert D. Fox, Ed.D.
T. Joseph Sheehan, Ph.D.

CURRENT AND FUTURE TEACHING RESPONSIBILITIES OF HOUSESTAFF

Moderator: Leonard E. Heller, Ed.D.

Panel: C. Earl Hill, M.D.
Sally Mattingly, M.D.

**Innovations in Medical Education Exhibits
November 10**

GME/GSA Plenary Session

COMBINING FORCES TO SURVIVE IN THE EIGHTIES

Innovations in Medical Education Exhibits

INNOVATIONS IN MEDICAL EDUCATION DISCUSSION GROUPS

Instructional Design or Evaluation of Introduction to Clinical Medicine Experiences

Moderators:
Richard Coulson, Ph.D.
Howard S. Barrows, M.D.

Instructional Design or Evaluation of Clinical Clerkships

Moderators:
Fredric D. Burg, M.D.
Harold G. Levine

Instructional Design or Evaluation of Residency Programs

Moderators:
John Lloyd, Ph.D.
Paula L. Stillman, M.D.

Instructional Design or Evaluation of Continuing Medical Education Programs

Moderators:
Philip G. Bashook, Ed.D.
Norman Stearns, M.D.

Computer Applications in Medical Education

Moderators:
Diane Butzin
David Swanson, Ph.D.

Interdisciplinary Health Education

Moderators:
Janet Pisaneschi, Ph.D.
Helen Robillard

Faculty Development

Moderators:
Thillard Jason, M.D., Ed.D.

Jane Westberg, Ph.D.
Educational Support Systems for Students

Moderators:
Marilyn Heins, M.D.
S. Scott Obenshain, M.D.

Innovative Approaches to Admissions and Student Financial Aid

Moderators:
N. Lynn Eckhert, M.D.
Jerry R. May, Ph.D.

November 11

GME Mini-Workshops

DEVELOPING CLERKSHIP RATING FORMS

Organizer: John H. Littlefield, Ph.D.

Faculty: Nancy Anthracite, M.D.
James Waldron, Ph.D.

INTERVIEWING CANDIDATES FOR RESIDENCY APPOINTMENTS

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

Faculty: William G. Barsan, M.D.
Rev. George F. Luthringer
Kenneth W. Rowe, Jr., M.D.

BASIC SCIENCE TEACHING AT THE BEDSIDE

Organizer: Murray Saffran, Ph.D.

Faculty: Roberto Franco-Saenz, M.D.
Murray Saffran, Ph.D.

A CRITICAL LOOK AT APPROACHES TO GRADING STUDENT PERFORMANCE

Organizer: Sue Fossen

Faculty: Sue Fossen
Terrence M. Leigh, Ed.D.
Jayne Middleton, Ed.D.

DIAGNOSING TEACHING AND LEARNING STYLES

Organizer: Russell F. West, Ed.D.

Faculty: Leo M. Harvill, Ph.D.
Russell F. West, Ed.D.

USING SIMULATIONS TO IMPROVE INSTRUCTION IN MEDICAL EDUCATION

Organizer: Harold G. Levine

Faculty: John F. Markus
Emil R. Petrusa, Ph.D.

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RESEARCH IN MEDICAL EDUCATION

November 8

PRESENTATION OF SYMPOSIA

INTERMEDIATE CAREER CHOICE PG I OF GRADUATES FROM NEW (AFTER 1964) AND LONG ESTABLISHED MEDICAL SCHOOLS (BEFORE 1964)

Organizer: Lawrence P. Tremonti, M.D.

Moderator: Edwin Hutchins, Ph.D.

Panelists: James G. Boulger, Ph.D.
 Hugh S. Fulmer, M.D.
 Edwin B. Hutchins, Ph.D.
 Lawrence P. Tremonti, M.D.

INCREASING BLACK ENROLLMENT: NEW STRATEGIES OF THE 80S AND 90S

Organizer: Mary Kay Schleiter, Ph.D.

Moderator: Alvin R. Tarlov, M.D.

Panelists: Mary Kay Schleiter, Ph.D.
 Louis W. Sullivan, M.D.
 William J. Wilson, Ph.D.

Presentation of Papers

ATTITUDES AND PATIENT CARE

Moderator: Jo Boufford, M.D.

Internal Medicine Residents' and Staff Physicians' Attitudes Toward Patients' Physical, Social, Psychological, and Health State Characteristics

Ilene B. Harris, Ph.D., et al.

Primary Care Versus Specialty Care Practice Choice: Attitudes Towards Chronic Illness and the Elderly

Karla J. Keith, et al.

A Model Geriatrics Curriculum: Implementation and Evaluation in Ten Medical Schools

Marcia R. Smith, Ph.D., et al.

PROFESSIONAL ATTITUDES AND CAREER CHOICE

Moderator: George Zimny, Ph.D.

A Case Specific Approach to Measuring Cancer Attitudes

Bruce C. Eshler, et al.

Personality and Professional Self-Concepts of Primary Care Residents

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

Medical Student Attitudes Toward Mental Ill-

ness as a Predictor of Choice of Psychiatric Specialty

Alan B. Wachtel, M.D., et al.

POSTGRADUATE EDUCATION SELECTION PROCESS

Moderator: Jack M. Colwill, M.D.

What are the Odds?: Applicant Characteristics and the Resident Selection Process

Lisa I. Leiden, Ph.D., et al.

Factors in Family Practice Residency Selection

Robert A. DiTomasso, Ph.D., et al.

Physician Location History as a Determinant of Regional Practice Location

Sandra R. Wilson, Ph.D.

November 10

PRESENTATION OF SYMPOSIA

A DEMONSTRATION AND DISCUSSION OF THREE MODELS FOR TEACHING CLINICAL REASONING SKILLS TO MEDICAL STUDENTS

Organizers: Glenn A. Fleming, Ed.D.
 Jon H. Levine, M.D.

Moderator: Paul Cutler, M.D.

Panelists: Howard S. Barrows, M.D.
 Paul Cutler, M.D.
 Jon H. Levine, M.D.
 Ollie J. Sahler, M.D.

COMPUTERS IN WHITE? WHAT SHOULD MEDICAL STUDENTS KNOW ABOUT COMPUTERS?

Organizer: Robert M. Rippey, Ph.D.

Moderator: Philip G. Bashook, Ed.D.

Panelists: James Gilbert
 Robert M. Rippey, Ph.D.
 Anthony E. Voytovich, M.D.
 Scott Wetstone, M.D.

THEORETICAL BASIS OF CLERKSHIP DESIGN

Organizer: Connie L. Kohler

Panelists: Stephen Abrahamson, Ph.D.
 David Irby, Ph.D.
 Marilyn L. Rothert, Ph.D.
 T. Joseph Sheehan, Ph.D.
 Frank T. Stritter, Ph.D.

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Psychiatric MICROCOMPUTER APPLICATIONS IN UNDER-GRADUATE CLINICAL TRAINING

Organizer: David B. Swanson, Ph.D.

N PROC- Moderator: Fredric D. Burg, M.D.

Panelists: Abdulla Abdulla, M.D.
Charles P. Friedman, Ph.D.
Peter Harasym, M.D.
David B. Swanson, Ph.D.

Selection Presentation of Papers

Selection EVALUATION OF INSTRUCTION

Moderator: Larry A. Sachs, Ph.D.

Crminant A Participant-Observational Study of a Course in Medical Microbiology
Harold G. Levine

Is Non-Response Bias Evident in Medical Student Assessment of Instruction?
Robert F. Rubeck, Ph.D., et al.

F THREE Students' Perceptions of Evaluative Feedback
SONING Doron H. Gil, Ph.D., et al.

CME NEEDS ASSESSMENT

Moderator: Stephen E. Goldfinger, M.D.

Decision-Making: An Alternative Approach to Needs Assessment and Objective Setting in Continuing Medical Education Program Planning
Paul E. Mazmanian, Ph.D.

What to Say in Giving the Diagnosis of Acute Lymphocytic Leukemia: Oncologists' and Parents' Perceptions
Larrie W. Greenberg, M.D., et al.

D MEDI Diabetes CME Through Record Review and
ERS? Patient Survey
T. Elaine Adamson, et al.

EVALUATION OF CLINICAL PERFORMANCE

Moderator: George D. Webster, M.D.

The Evolution of Competency in Internal Medicine: The Validity of a Clinical Performance Measure

GN John C. Peirce, M.D., et al.

Measurement of Clinical Competence of Residents Using Patient Instructors
Paula L. Stillman, M.D., et al.

Professional Attitudes and Interpersonal Relationships of Physicians: Are They a Problem?
Mary W. Herman, Ph.D., et al.

Utilization of Videotaped Observations to Assess Physician Care: A Methodology for Evaluating Treatment
Barbara Gerbert, Ph.D., et al.

EVALUATION METHODOLOGY

Moderator: John S. Lloyd, Ph.D.

A Comparison Between Judges' Conjectures and Actual Performance of Minimally Qualified Examinees
Ernest N. Skakun, et al.

Two Different Methods of Testing Medical Students: A Comparison of Modified Nedelsky Minimum Pass Levels and the T-Score Distribution in Evaluating Medical Student Achievement
Leslie A. Walker-Bartnick, et al.

Isomorphic Patient Management Problems: A Counterpart to Parallel Multiple Choice Tests
Daniel S. Fleisher, M.D., et al.

EVALUATING PROBLEM SOLVING SKILLS

Moderator: Christine McGuire

Problem Solving Within a Limited Content Area
Michael B. Donnelly, Ph.D., et al.

The Validation of Problem Solving Measures: Multitrait-Multimethod Matrix Analysis
Terrill A. Mast, Ph.D., et al.

Manifestations of Expertise in Recall of Clinical Protocols
Linda J. Muzzin, et al.

LEARNING IN THE CLINICAL YEARS

Moderator: Charles W. Dohner, Ph.D.

The Etiology of Diagnostic Errors: Process or Content? An Exploratory Study
Georges Bordage, M.D., Ph.D., et al.

Influence of Site on Ambulatory Care Residency Education in Internal Medicine
Sharon K. Krackov, Ed.D., et al.

A Multicenter Evaluation of Primary Care Residency Training at Harvard: Objectives, Strategy and Implementation
Allan H. Goroll, M.D., et al.

PREDICTABILITY OF ADMISSIONS CRITERIA

Moderator: Kaaren I. Hoffman, Ph.D.

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Admissions Preference as a Predictor of Pre-clinical Performance

Richard A. DeVaul, M.D., et al.

Selective Interviewing: Identifying Congruence with Institutional Goals Among Academically Qualified Medical School Applicants

Gerry R. Schermerhorn, et al.

Prediction of Clerkship Performance Using the New MCAT Examination: An Attempted Application of Canonical Redundancy Analysis
Jan D. Carline, Ph.D., et al.

EVALUATING CME

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

Pilot Analysis of an Evaluation Mechanism for Continuing Medical Education Short Courses

Lynn Curry, Ph.D., et al.

An Evaluation of the Composition of the Educational Audience on the Effectiveness of Continuing Education in Changing Physicians' Knowledge and Behavior

Carl W. White, M.D., et al.

The Effect of a Model Medical Care Evaluation Program on Physician Knowledge and Performance

Joseph A. Maxwell, et al.

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Minutes of AAMC Assembly Meeting

November 9, 1982

Washington Hilton Hotel, Washington, D.C.

Call to Order

Dr. Thomas K. Oliver, AAMC Chairman, called the meeting to order at 8:15 a.m.

Quorum Call

The Chairman recognized the presence of a quorum.

Consideration of the Minutes

The minutes of the November 3, 1981, Assembly meeting were approved without change.

Report of the Chairman

Dr. Oliver reported that during his tenure as Chairman of the Association he had taken a leave of absence to spend time at the AAMC offices and to meet with policymakers on Capitol Hill and in the Executive Branch. He had concentrated on advancing the Association's positions known in the areas of research and research training and student financial assistance.

Dr. Oliver also reported on the Association's relationships with other professional organizations, including the Council for Medical Affairs, the Association of Academic Health Centers, the Accreditation Council for Graduate Medical Education, and the Accreditation Council for Continuing Medical Education.

Harvard Medical School was congratulated on the occasion of its bicentennial anniversary, and the centennial celebrations of the University of Pittsburgh School of Medicine, the University of Colorado School of Medicine, and the University of Minnesota School of Medicine were recognized.

Dr. Oliver extended a special thanks to the following individuals whose terms on the Association's Executive Council or Administra-

tive Boards had expired: From the Executive Council, Julius R. Krevans, Virginia V. Weldon; from the Council of Deans, John Eckstein, Leonard Napolitano; from the Council of Academic Societies, T. R. Johns, Daniel X. Freedman; from the Council of Teaching Hospitals, Fred Cowell, Stuart Marylander, John Reinertsen; from the Organization of Student Representatives, Lisa Capaldini, Paul Organ, Linda McKibben, Beth Fisher, Ron Voorhees, Michael Tom, David Baum.

Report of the President

Dr. John A. D. Cooper briefly described a number of the programmatic activities in which the Association had been engaged during the preceding year, including the projects on the General Professional Education of the Physician and the Regional Institutes on Geriatrics and Medical Education. He also listed a number of publications issued by the Association.

Dr. Cooper provided an update on the status of the Association's National Medical Research Awareness project and indicated that the planning stage was nearing completion and that he and Dr. John F. Sherman would be meeting with chief executive officers of pharmaceutical firms to see if sufficient funds could be raised to proceed with the project.

The entering class for medical schools in the 1982 academic year reflected a slight decline of about .5 percent from the 1981 level. In all, the applicant pool had declined nearly 3 percent, and early indicators point to another 6-7 percent decline in the applicant pool for the 1983 entering class. The number of women applicants and matriculants continued to show a slight increase, with underrepresented minorities staying about the same.

Dr. Cooper reported on a number of legislative issues that could be expected to arise during the "lame duck" session of the 97th Congress. These included appropriations for the Department of Health and Human Ser-

vices, legislation renewing certain NIH authorities, and bills relating to the use of animals in biological and behavioral research. He also mentioned a change in the climate of Capitol Hill, commenting that the Association was often faulted for not having a political action committee or a network for mobilizing votes during Congressional elections.

Report of the Council of Deans

Dr. William H. Luginbuhl reported that the Council of Deans had had a good attendance at the spring meeting in Kiawah Island, South Carolina. Dr. Richard Janeway was named Chairman of the Council and Dr. Edward J. Stemmler Chairman-Elect. Dr. Luginbuhl also expressed his appreciation to Dr. Eckstein and Dr. Napolitano for their service on the COD Administrative Board.

Report of the Council of Academic Societies

Dr. David Brown indicated that Dr. Frank Wilson would be the new Chairman of the CAS and Dr. Robert Hill its Chairman-Elect. Elected to new terms on the CAS Administrative Board were Frank Moody, Joseph Johnson, Virginia Weldon, and Lowell Greenbaum.

During the annual meeting the CAS had met jointly with the Organization of Student Representatives to discuss aspects of the Association's project on the General Professional Education of the Physician. The CAS had also discussed basic science teaching in medical schools and concluded that improved appreciation of the basic sciences by physicians was needed.

The CAS was planning an interim meeting in February modeled after its 1982 interim meeting at which more than 80 academic society representatives had met with 40 Congressional staff members.

Report of the Council of Teaching Hospitals

Dr. Mitchell Rabkin reported that the AAMC's study of the distinctive characteristics and related costs of teaching hospitals was nearing completion. Reports on diagnosis related groups and disease staging methodologies had already been issued, and two final reports were being prepared. One would be an internal COTH document presenting data on the hos-

pitals that participated in the study, and the other would be a public document on the characteristics and costs of teaching hospitals.

Mr. Mark Levitan succeeds Dr. Rabkin as Chairman of COTH, and Mr. Earl Frederick becomes Chairman-Elect.

Report of the Secretary-Treasurer

Dr. Rabkin referred the members of the Assembly to the detailed Treasurer's report in the agenda book and indicated that the Audit Committee had found no irregularities in the Association's annual audit report.

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

Report of the Organization of Student Representatives

Dr. Grady Hughes reported that the OSR had changed its annual meeting format this year and as a result had adopted no resolutions. Instead, the OSR had met in small group sessions to discuss issues in the areas of strategy for financial aid, educational techniques, ethical and social concerns of physicians, information management techniques, house staff involvement in the AAMC, and personal objectives in medical school.

The OSR had published three issues of *OSR Report* during the past year, including one issue authored by Board members, an idea that had been favorably received by medical students.

The OSR was interested in maintaining an active role in the Association's General Professional Education of the Physician project and had representatives on the three working groups. Medical students were also being encouraged to involve themselves in the project discussions at the institutional level. Other substantive matters dealt with by the OSR included student financial assistance and career counseling.

Ed Schwager was named Chairperson of the OSR, and Pamelyn Close Chairperson-Elect.

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:

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Institutional Membership: East Tennessee State University College of Medicine; Oral Roberts University School of Medicine.

Provisional Institutional Membership: Mercer University School of Medicine.

Academic Society Membership: American College of Neuropsychopharmacology; American Institute of Ultrasound in Medicine.

Teaching Hospital Membership: Bellevue Hospital Center, New York, New York; District of Columbia General Hospital, Washington, D.C.; Franklin Square Hospital, Baltimore, Maryland; Grant Hospital, Columbus, Ohio; Maimonides Medical Center, Brooklyn, New York; Ohio Valley Medical Center, Inc., Wheeling, West Virginia; St. Joseph's Hospital and Medical Center, Paterson, New Jersey.

Corresponding Membership: East Suburban Health Center, Monroeville, Pennsylvania; Memorial Hospital, Chattanooga, Tennessee; Providence Medical Center, Baltimore, Maryland; St. Mary's Medical Center, Evansville, Indiana; West Suburban Hospital, Oak Park, Illinois.

Individual Membership: List attached to archive copy of these minutes.

Distinguished Service Membership: Robert M. Berne, A. Jay Bollet, Carmine D. Clemente, Jack W. Cole, John A. Gronvall, Julius R. Krevans, Charles B. Womer.

Emeritus Membership: William Fleeson, Clifford Grulee.

tive Council, COTH representative: Robert Frank (two-year term).

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.

Report of the General Professional Education of the Physician Project

Dr. John A. Gronvall, a member of the advisory panel for the General Professional Education of the Physician project, gave a brief report on the status of this project. A number of deans expressed their concern about what they felt was a premature release of information from the study. Dr. Gronvall assured them that the advisory panel had not reached final conclusions at this point and would be consulting with the governance structure as the study developed.

Installation of New Officers

Dr. Steven C. Beering was installed as the AAMC's new Chairman.

Resolution of Appreciation

ACTION: On motion, seconded, and carried, the Assembly adopted the following resolution of appreciation:

WHEREAS, Dr. Thomas K. Oliver, Jr. has faithfully served American medicine as a caring physician, inspiring teacher, thoughtful scientist and skillful administrator and,

WHEREAS, he has distinguished himself by his exemplary contributions to the Association of American Medical Colleges as a member and Chairman of the Council of Academic Societies Administrative Board, the Accreditation Council for Graduate Medical Education, the Executive Council and the Assembly,

NOW THEREFORE BE IT RESOLVED that the Association express our sincere appreciation for his dynamic leadership and careful stewardship and add our best wishes for the future.

Adjournment

The Assembly adjourned at 9:10 a.m.

Report of the Resolutions Committee

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

Report of the Nominating Committee

Dr. Robert G. Petersdorf, Chairman of the AAMC Nominating Committee, presented the report of that 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: Robert M. Heyssel; Executive Council, COD representatives: Louis J. Kettel, Fairfield Goodale; Executive Council, CAS representative: Joseph E. Johnson, III; Execu-

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Annual Report 1981-82

**Note: The President's Message appeared in the
December 1982 issue of the *Journal of Medical
Education* as an editorial.**

Executive Council, 1981-82

Thomas K. Oliver, Jr., Chairman
Steven C. Beering, Chairman-Elect
John A. D. Cooper, President

Council Representatives:

COUNCIL OF ACADEMIC SOCIETIES

David M. Brown
Daniel X. Freedman
Virginia V. Weldon
Frank C. Wilson, Jr.

DISTINGUISHED SERVICE MEMBER

Manson Meads

COUNCIL OF DEANS

Steven C. Beering
John E. Chapman

John W. Eckstein
Richard Janeway
William H. Luginbuhl
Richard H. Moy
Leonard M. Napolitano
M. Roy Schwarz
Edward J. Stemmler

COUNCIL OF TEACHING HOSPITALS

Mark S. Levitan
Stuart J. Marylander
Mitchell T. Rabkin
John Reinertsen

ORGANIZATION OF STUDENT REPRESENTATIVES

Grady Hughes
Edward Schwager

Administrative Boards of the Councils, 1981-82

COUNCIL OF ACADEMIC SOCIETIES

David M. Brown, Chairman
Frank C. Wilson, Jr., Chairman-Elect
Bernadine H. Bulkley
David H. Cohen
Daniel X. Freedman
William F. Ganong
Lowell M. Greenbaum
Robert L. Hill
T. R. Johns, III
Joseph E. Johnson, III
Douglas Kelly
John B. Lynch
Virginia V. Weldon

COUNCIL OF DEANS

William H. Luginbuhl, Chairman
Richard Janeway, Chairman-Elect
Steven C. Beering
Arnold L. Brown
John E. Chapman
D. Kay Clawson
William B. Deal
John W. Eckstein
Richard H. Moy
Leonard M. Napolitano
M. Roy Schwarz
Edward J. Stemmler

COUNCIL OF TEACHING HOSPITALS

Mitchell T. Rabkin, Chairman
Mark S. Levitan, Chairman-Elect
James W. Bartlett
Fred J. Cowell
Jeptha W. Dalston
Spencer Foreman
Robert E. Frank
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
Stuart J. Marylander
John A. Reinertsen
Haynes Rice
John V. Sheehan

ORGANIZATION OF STUDENT REPRESENTATIVES

Grady Hughes, Chairperson
Edward Schwager, Chairperson-Elect
David Baum
Lisa Capaldini
Pamelyn Close
Beth Fisher
Linda McKibben
Paul Organ
David Thom
Michael Tom
Ron Voorhees

The Councils

Executive Council

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

The traditional December retreat for newly elected officers and senior staff of the Association continued discussions initiated at a special joint meeting of all Administrative Boards in September 1981. That session, "Strategies for the Future," had focused on issues facing medical schools and teaching hospitals and their faculties and students in the 1980s. Retreat participants studied these issues and related data and developed a work plan setting forth both short-term and long-term goals and priorities for the Association. The work plan was further reviewed and refined throughout the year in discussions at the Administrative Boards and Executive Council meetings.

As the President's fiscal year 1983 budget was developed, and as the legislative process progressed, the Executive Council reaffirmed as the top priorities for the Association research and research training, student financial assistance, and Medicare and Medicaid. In each of these areas the Council reviewed and acted on many policy issues.

The fiscal year 1983 budget request for the National Institutes of Health had programmatic implications that concerned Association constituents. One component of the request in particular, a proposal to limit indirect cost reimbursement on research awards to 90% of the negotiated rate, was viewed as seriously threatening to the institutional research base in medical centers. The Executive Council opposed such limitations despite the possibility that the alternative would be less money avail-

able for research awards. The balance in funding between intramural and extramural research was also discussed. Although support for the NIH intramural program was reiterated, the Council reminded NIH that the reasons given for the increased funding for the intramural program—higher energy prices, salary increases, and higher equipment and supply costs—also obtained for the extramural program.

The Executive Council reviewed several bills renewing or revising expiring NIH authorities. Of particular concern was the potential fragmentation of the research endeavor by the proliferation of separate institutes.

The Executive Council authorized an effort to determine the feasibility of initiating a nationwide public relations effort to inform the public and policy-makers about the benefits of and need for strong support for biomedical and behavioral research. If undertaken, the effort could culminate in the designation of a National Medical Research Month.

The First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was, in general, favorably received by the Executive Council. An Association response to the report identified specific problems relating to inadequate definition of adverse reactions, research involving institutionalized mentally disabled persons, and reporting requirements.

After discussing federal efforts to develop and evaluate methods of containing Medicare and Medicaid expenditures, the Executive Council directed Association staff to actively pursue explicit recognition of hospital patient mix, including differences in diagnosis, intensity of illness and type of patient, in all hospital payment limitations and prospective payment systems. This position also guided the Executive Council as it reviewed the proposed Medicare prospective payment system developed by

the American Hospital Association.

As a parent organization of the Accreditation Council for Graduate Medical Education and the Accreditation Council for Continuing Medical Education, the Association must review and approve policy decisions by these organizations. The Executive Council approved a revision to the ACGME general essentials to allow graduates of schools accredited by the Liaison Committee on Medical Education and the American Osteopathic Association to enter graduate medical education without further examination or other requirements; graduates of other schools are required to pass an ACGME-approved examination of their cognitive skills. For the ACCME, the Executive Council approved the Essentials for the Accreditation of Sponsors of Continuing Medical Education and a statement on eligibility for accreditation.

The Executive Council endorsed the recommendations of an AAMC report on *Academic Information in the Academic Health Sciences Center*. The Council also approved a change in the medical school admissions "traffic rules" that would extend the period in which schools could offer acceptances without jeopardizing the Early Decision Program.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees. An *ad hoc* Committee on Health Planning, chaired by C. Thomas Smith, presented a report that was adopted at the Council's April meeting. The Association position supported streamlined community-based health planning with mandatory state certificate of need programs and an explicit recognition of the unique roles and needs of academic medical centers and teaching hospitals.

The *ad hoc* Committee on the Maintenance of High Ethical Standards in the Conduct of Research, under the chairmanship of Julius R. Krevans, was established in response to Executive Council concerns that the wide attention received by isolated instances of misconduct by biomedical investigators would call into question the integrity of the whole research enterprise. The committee report, as adopted by the full Council, emphasizes the critical importance of maintaining public trust in the research proc-

ess and also urges faculties to assume primary responsibility for promoting an environment fostering the highest principles of honesty and openness in research. The report also provides prototype guidelines and procedures to assist schools in dealing with allegations of fraud.

During the course of the year the Executive Council also reviewed the activities of the Advisory Panel for the General Professional Education of the Physician project and the Steering Committee of the Regional Institutes in Geriatrics and Medical Education effort.

In September the Executive Council had a special briefing session for the Administrative Boards of the Organization of Student Representatives, the Council of Teaching Hospitals and the Council of Academic Societies to consider issues relating to graduate medical education. The program was similar to one sponsored by the Council of Deans at its June meeting. Following up on these briefings, the Executive Council discussed the problem of maintaining sufficient residency positions for U.S. medical school graduates.

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

The Executive Council, along with the Secretary-Treasurer, Executive Committee and the Audit Committee, exercised careful scrutiny over the Association's fiscal affairs and approved a modest expansion in the general funds budget for fiscal year 1983.

The Executive Committee met prior to each Executive Council meeting and conducted business by conference call as necessary. During the course of the year the Executive Committee met with Donald Custis, chief medical director of the Veterans Administration Department of Medicine and Surgery, James Wyngaarden, director of the National Institutes of Health, Robert Rubin, assistant secretary for planning and evaluation, DHHS, and Congressman Edward Madigan.

Council of Deans

The activities of the Council of Deans in 1981-82 were dominated by its two major meetings—

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the business meeting at the Association's annual meeting in Washington, D.C. and the spring meeting at Kiawah Island, South Carolina. In addition, the COD Administrative Board met quarterly to review items on the AAMC Executive Council agenda of significant interest to the deans and to carry on the business of the COD. More specific concerns were addressed by smaller groups of deans brought together by common interests.

At the program session of the annual business meeting, Donald L. Custis, chief medical director of the VA, introduced Medical District Initiated Program Planning, a strategic planning effort to curtail the centralization of authority within the VA and place greater responsibility at the local level for identifying and meeting essential priorities in an increasingly resource-constrained future. Murray Mitts, director of program analysis and development at the VA and Malcom Randall, director of the VA Medical Center in Gainesville, Florida further elaborated on the organization and process of MEDIPP. The business meeting also considered several Assembly action items including election of institutional and distinguished service members and proposed bylaw and COD rules and regulation changes. Additional discussions centered on the role medicine, particularly academic medicine, needs to play in the problems faced by society, such as care for the elderly.

One hundred eight deans attended the March 28-31 spring meeting devoted to "Academic Medicine—Exploring the Tasks at Hand: Expanding Resources-Contracting Programs." Robert Blendon, vice president of the Robert Wood Johnson Foundation, provided a look at the economic and political climate for medicine, and AAMC President John A. D. Cooper discussed the status of medical education in the U.S. Reflections on the relationships of academic medicine and the profession were presented by Lowell H. Steen, immediate past chairman, American Medical Association Board of Trustees Lattie F. Coor, president of the University of Vermont, Robert L. Friedlander, president of Albany Medical College, W. Donald Weston, dean at Michigan State University College of Human Medicine, and John Gronvall, dean at the University of Michigan School of Medicine, discussed strategies and

programs of their institutions to introduce more efficient management, consolidate programs, and develop an experimental budgeting system. A perspective on strategies for developing philanthropy for institutional support was provided by J. Michael Mattsson, executive director of the Development Office at the University of Utah. Jeff Goldsmith, director, Office of Health Planning and Health Regulatory Affairs, University of Chicago Medical Center, presented an informative discussion about the future of academic medical centers in a price competitive market. The program concluded with a presentation by Donald L. Custis, chief medical director, Veterans Administration, setting out his plans and perspectives on the future of VA-medical school affiliations. The presentations stimulated much discussion among the deans.

The spring meeting began with an orientation session for new deans at which they were introduced to the AAMC leadership and staff and briefed on the Association's resources and programs. The business meeting included discussions of the AAMC work plan entitled "Strategies for the Future," consideration of a proposed National Medical Research Month, review of a preliminary report on medical school approaches to problems in student financial assistance, a suggested expansion of VA faculty retirement options, a report on academic information in the health sciences center, a progress report on the project to study the general professional education of physicians, and a suggested expansion of the AAMC's data collection and reporting activities.

Additional agenda items included the proposed appointment of an *ad hoc* Committee on the Promotion of Ethical Standards in Research; the progress of the Regional Institutes on Geriatrics and Medical Education; the Clinical Evaluation Project; and AAMC position statements on the Small Business Innovation Development Act, the economic and social ramifications of biomedical research, and the impact of the President's FY1983 budget request on students' ability to finance their education.

Several items considered by the COD Administrative Board during its quarterly meetings deserve special note. The Board considered and endorsed a proposed Association response

to the report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. It deliberated extensively on the development of an AAMC position on national health planning legislation. In addition, the Board offered its suggestions on the programmatic implications of the NIH budget.

Sections of the Council meeting during the year were the Southern deans, the Midwest deans, and the deans of new and developing community-based medical schools. The deans of private-freestanding schools conducted a special meeting session at the spring meeting.

Council of Academic Societies

Two major meetings dominated the 1981-82 activities of the CAS, which now has 73 academic societies representing over 100,000 U.S. medical school faculty members and others from the basic and clinical science disciplines.

At the 1981 fall meeting, the CAS sponsored a plenary session and discussion groups on "Basic Science Education as the Foundation for Advanced Medical Practice." Frederick E. Shideman, chairman of pharmacology at the University of Minnesota, contrasted the content and scope of instruction in pharmacology in the past and present and speculated on future developments. Rubin Bressler, chairman of medicine at the University of Arizona, discussed the challenge for basic and clinical scientists to identify essential bioscience knowledge to be learned by students. Robert W. Berliner, dean of the Yale University School of Medicine, identified methods faculty might employ to develop the future physician's ability to assimilate and utilize new scientific developments. Small group sessions discussed the appropriate college preparation for medical school, the role of the basic scientist in clinical departments, reinforcement of the basic sciences during clinical education, and identification of the essential scientific concepts for students.

The January Interim Meeting of the CAS was the best-attended meeting in the Council's 14-year history. Key congressional staff and executive branch officials were invited to participate in a public affairs symposium on "Biomedical Research: A Partnership Between the Federal Government and the Academic

Medical Center." A plenary session began with a presentation by Bernadine Healy Bulkey, professor of medicine at the Johns Hopkins University School of Medicine, who discussed the development of academic medical institutions as the stewards of the biomedical research enterprise. John K. Iglehart, special correspondent to the *New England Journal of Medicine*, provided an informed observer's view of federal/public expectations for biomedical research. Assistant Secretary for Health Edward N. Brandt discussed the federal role in the biomedical research effort. Dr. Brandt cited diversity, independence, competitiveness, and the potential for cross-fertilization as the most significant attributes of the nation's biomedical research enterprise. Following the plenary session, small groups of CAS representatives and federal policymakers had an opportunity to discuss informally the future of the biomedical research partnership between the federal government and the academic community.

The CAS Administrative Board conducted the business that arose throughout the year during quarterly meetings held before each Executive Council meeting. At its April meeting, the CAS Board met with William F. Raub, NIH associate director for extramural research and training and Joseph Rall, deputy director for science at NIH, regarding the intramural and extramural research budgets and the peer review process. May Ellen Jones, chairman of biochemistry at the University of North Carolina, discussed the intramural peer review process from her perspective as a member of the Board of Scientific Counsellors of the National Heart, Lung and Blood Institute. The April meeting also featured a joint session with the OSR Administrative Board to discuss the role of student/faculty relationships in the nurturance of curiosity and creativity and the development of high ethical standards. At the June meeting of the Board, Barbara J. Culliton, news editor of *Science* magazine, reviewed the increase in industrial investment in academic science. In September, a joint meeting of the CAS, COTH and OSR Boards considered the need to maintain sufficient graduate medical education opportunities for graduates of U.S. medical schools.

The quarterly CAS *Brief* informed medical school faculty about current issues in medical

education. The Association's CAS Services Program assisted societies desiring special legislative tracking and office management services. Six societies participated in the program in 1981-82: American Federation for Clinical Research, Association of Professors of Medicine, American Academy of Neurology, American Neurological Association, Association of University Professors of Neurology and Child Neurology Society.

Council of Teaching Hospitals

The Council of Teaching Hospitals held two general membership meetings during 1981-82. The theme for the COTH general session at the fall annual meeting was "Implementing Competition in a Regulated Health Care System." The featured speaker was Walter J. McNeerney, then president of the Blue Cross/Blue Shield Associations, who warned that the "public mood toward health spending is becoming more severe" and is likely to have a major impact on the way teaching hospitals and others do business. He saw providers looking toward "greater aggregation of services as a means to compete" and the health care industry becoming increasingly segmented and proprietary in nature. He suggested that teaching hospitals seek economies of scale, minimize regulation effects, find new sources of capital and new support for research, husband good management personnel, consider sharing teaching programs, restructure organizationally, and take innovative approaches to the delivery of health care.

The Fifth Annual COTH Spring Meeting was held May 12-14 in Boston. Attracting a record 225 chief executives and their associates, the meeting focused on the increasing competition among hospitals and other providers for patients, new programs and services, community support and financial resources. The meeting began with three papers describing major environmental features faced by hospitals. John Iglehart, special correspondent for the *New England Journal of Medicine*, addressed "The Washington Perspective: Political and Budgetary Expectations for 1983 and Beyond." He noted that the trends under the Reagan Administration have been encouraging competition and permitting the free market to take its

toll, a reexamination of the limits of public benevolence and federal government responsibilities, and less government regulation and reduced taxation. He cautioned that teaching hospitals no longer live in a resource rich world and face increasing pressure to down-size and identify their component costs more specifically.

J. Robert Buchanan, then president of Michael Reese Hospital and Medical Center, addressed "Regulation, Competition, and Physician Manpower Projections: The Issues Before Us." Dr. Buchanan described the evolution of present national health policies and potential impacts of increased physician supply. Bruce C. Vladeck, assistant vice president at the Robert Wood Johnson Foundation and former assistant commissioner of health responsible for the New Jersey State Rate Setting Commission, spoke on "State Rate Review and Health Planning: Regulatory Alternatives to Competition." He began by stating that "the evidence accumulated has demonstrated that state rate regulation of hospitals works," and cited reports which found that the rate of hospital cost increase in the six states with mandatory state rate regulation had been 2-3% lower annually than in other states.

In a special presentation, Donald L. Custis, chief medical director of the Veterans Administration, discussed policy developments in the VA and their implications for the private sector. Other speakers included Scott S. Parker, president of Inter-Mountain Health Care, Inc., who spoke on "Not-For-Profit Chain Operations: Assessing Their Impact and Looking to Their Future"; Allen M. Hicks, chairman of the board of Voluntary Hospitals of America and president of Community Hospital of Indianapolis, who spoke on the VHA collective approach; Myles P. Lash, executive director of the Medical College of Virginia Hospitals, and Fred Munson, associate professor at the University of Michigan's graduate program in hospital administration, who addressed "Competition Confronting University Hospitals: Its Impact on Patterns of Governance"; Karl G. Mangold, president of the Fischer-Mangold Group of Emergency Physicians, whose presentation was entitled "Non-Hospital Based Competition: An Entrepreneurial View"; J. D. Epstein, principal in the Houston-based law firm of

Wood, Lucksinger and Epstein, who discussed "Reorganizing for Operating and Financial Flexibility"; Jeff Goldsmith, director of planning at the University of Chicago Medical Center, who discussed the topic of "Marketing the Teaching Hospital's Products"; and Robert L. Biblo, president of the Health Insurance Plan of Greater New York, on "Negotiating with Teaching Hospitals: An HMO Point of View." The COTH Spring Meeting concluded with a summary and analysis of the various presentations and some personal commentary from Robert Zelten, associate professor at the Wharton School of the University of Pennsylvania.

The COTH Administrative Board met five times to conduct the Council's business and to review and discuss Executive Council agenda items. A major agenda item continued to be the various "pro-competition" legislative proposals, their potential impact on teaching hospitals, and alternatives for addressing the issues. The Board neither formally endorsed nor opposed such legislation and specifically examined such relevant issues as Medicare and Medicaid participation, charity and uncompensated care, pricing of plans, a special fund for the societal contributions of teaching hospitals, and an evaluation commission. The Administrative Board also examined and endorsed in concept the American Hospital Association's proposed Medicare prospective payment system.

In other deliberations the Administrative Board focused on the AAMC's study of teaching hospital characteristics, the report of the Association's *ad hoc* Committee on Health Planning, the impact of proposed Medicare and Medicaid budget cuts and tax-exempt financing restrictions, the Health Care Financing Administration's regulatory proposal for prospective reimbursement of dialysis services, the declining availability of graduate medical education positions at teaching hospitals, and AAMC sponsorship of a capital purchasing program. Preceding three of its meetings, the Administrative Board held informal discussions with guest speakers. Harold Cohen, executive director of Maryland's Health Services Cost Review Commission, discussed the evolution and success of hospital rate setting in his state. Willis Goldbeck, executive director of the Washington Business Group on Health, reviewed de-

velopments in the area of business coalitions, employer self-insurance, and preferred provider arrangements. Paul Ginsberg, Congressional Budget Office deputy assistant director for income security and health, discussed CBO's evaluation of proposed Medicare and Medicaid budget reductions and an assessment of the American Hospital Association's prospective Medicare payment proposal.

Organization of Student Representatives

As evidenced by attendance at regional spring meetings and by the leadership roles undertaken by OSR members within their institutions, the Organization of Student Representatives continues to grow both in numbers and influence. One hundred eighteen U.S. medical schools presently participate, and 95 student representatives to the 1981 annual meeting. Attendees shared experiences during discussion sessions on a wide variety of topics including student political activism and roadblocks to psychosocial development during medical school. They also heard presentations on clinical evaluation and on the prevention of failure during medical education. The main program, "Tomorrow's Medicine: The Practice, The Economy, The Science," was presented by Alvin Tarlov, professor of medicine, University of Chicago Pritzker School of Medicine; Jeff Goldsmith, director, Office of Planning and Health Regulatory Affairs, University of Chicago Medical Center; and Jane Henney, special assistant for clinical affairs, National Cancer Institute. Also at the annual meeting the representatives passed seventeen resolutions to guide the deliberations of the eleven-member Administrative Board over the year.

The Board met prior to each Executive Council meeting to coordinate OSR activities and to consider Executive Council agenda items. During a special session in April the Administrative Boards of OSR and CAS met to share perspectives on the faculty's role in nurturing students' curiosity and in motivating adherence to high ethical standards. This was judged quite useful, and a joint annual meeting session for the memberships of both groups was planned. At each of its meetings the OSR Board heard progress reports on the General Profes-

sional Education of the Physician project and on the status of funding for student financial aid programs and for Medicare and Medicaid. The OSR Chairperson also shared updates on activities of the Consortium of Medical Student Groups, and progress was notable in overlap of goals and frequency of communications among the groups. Two areas to which the Board gave particular attention over the year were the problem of cheating in medical school and students' need for improved career counseling. At the 1981 annual meeting, OSR members completed a questionnaire regarding the former; results revealed skepticism about the utility of honor codes and a general paucity of activities to foster ethical behavior. The OSR Board explored ways to assist the schools in dealing with such issues. The Board also reviewed reports and descriptions gathered at regional meetings on dilemmas students face in the residency and specialty selection process and the kinds of assistance schools provide;

methods to improve the quality and dissemination of available information were examined.

Activities in which all members of the OSR were invited to participate were numerous this year. The most important of these was the organization of massive letter-writing campaigns in early spring in response to the Reagan Administration's proposal to eliminate professional students' eligibility under the Guaranteed Student Loan program; Congress did not approve this proposal. OSR members also worked with student deans to institute housing-sharing services for seniors taking off-campus electives to prevent paying double rent and, at schools with upcoming LCME site visits, shared guidelines for input with other student leaders. Two issues of *OSR Report*, "Coming to Terms with Your Failed Expectations: A Non-credit Course for Physicians-in-Training" and "The Rising Costs of Health Care and the Responsibilities of Medical Students" were distributed to all medical students.

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National Policy

The imperative to gain control over the economy continued to dominate the national policy scene this year. Presidential determination for spending cuts in virtually every budget category but defense funding was maintained at a high level. Consequently, pressure for retrenchment pervaded the 97th Congress as it closed its first and resumed work during its second session. Implementation of previously enacted reductions and the achievement of further cutbacks preoccupied the congressional schedule as fiscal austerity remained the central focus of federal policy.

Despite overall continuity, perceptible policy shifts did surface. The new thrust of turning federal responsibility back to non-federal sectors of society was strongly supported by the executive's "new federalism" proposal. However, the response of the legislature and the governors was wary and there was growing recognition that achievement of the general presidential goals of lower taxes, a lower deficit, increased defense spending, and preservation of essential non-defense programs was an impossibility.

Consistent with the centrality and pervasiveness of fiscal problems, budget and appropriations legislation preoccupied the attention of the Congress and hence of the Association.

Wrapping up the FY 1982 funding cycle proved to be arduous. As the start of FY 1982 approached, none of the necessary appropriation bills had been enacted. Consequently, as has become common, Congress passed what was to be the first of four temporary funding measures. The first continuing resolution provided for Department of Health and Human Services programs to be funded at the lower of their FY 1981 level or the amount in the House approved FY 1982 DHHS appropriation bill. The action effected funding reductions for virtually all National Institutes of Health programs of interest to the Association. The Veterans Administration was funded at the levels

agreed to during the House-Senate conference on its FY 1982 appropriations bill, a measure providing a respectable increase in support for medical and prosthetic research.

In the meantime, President Reagan suddenly called for a reduction in FY 1982 spending 12% below the levels proposed in his March budget request. The Office of Management and Budget directed government agencies to keep their FY 1982 outlays to the reduced level, on the justification that the continuing resolution was a funding ceiling rather than a spending mandate. Since no formal deferral message was sent, this constituted an illegal impoundment of funds. In compliance, the NIH cut all awards, and the VA research effort was severely curtailed.

Confusion deepened with the President's veto of the initial second continuing resolution which called for a 2% reduction in discretionary programs. Unable to override the veto, the Congress enacted a one month extension of the first resolution. The action prolonged a stalemate between a President, insisting on stringent fiscal restrictions, and a thin majority of the Congress trying to comply without wreaking severe damages on social programs.

Enactment of the third continuing resolution for FY 1982 only partially restored the President's 12% cut. It provided for funding of DHHS programs at the lower of the levels passed by the full House or approved by the Senate Appropriations Committee. In addition, it prescribed a 4% across the board cut that permitted reduction of up to 6% in certain individual programs. The action yielded a bare 2% increase over the FY 1981 NIH funding level and reduced the Alcohol, Drug Abuse and Mental Health Administration research and training functions below the FY 1981 level. A special provision mandating that the reductions were not to terminate any program slated for funding by at least one body allowed continuation of the Health Professions Student

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Loan program at the extremely modest House funding figure.

Under the third resolution, all NIH awards were issued with reductions averaging 4%, while earlier awards that had been cut by 12% received partial restoration to the new levels. The percent of approved competing awards funded fell as did the number of research trainees supported. Institutional support for research training programs was cut by one-third to one-half.

For the VA, \$22.5 million was eliminated from the level agreed to in the conferenced FY 1982 VA appropriation bill, lowering support for VA research 8.5% below the FY 1981 figure.

Continued failure to pass some appropriations bills, including one for DHHS, eventually required a fourth continuing resolution. Enacted at the end of March, the final resolution simply extended the provisions of the third resolution to the end of this fiscal year. For the third successive year the DHHS operated under a continuing resolution rather than a normal appropriation.

A FY 1982 appropriations bill for the VA was eventually enacted, after being vetoed and revised in accordance with presidential design. Essentially, it provided support equal to that provided under the third continuing resolution.

Before FY 1982 funding was settled, the FY 1983 cycle got underway. The President's budget request for FY 1983 embodied the by-then familiar priorities of preserving the tax reductions enacted in 1981, reducing spending growth except in defense, and alleviating the federal regulatory burden. Although the President had announced an increase for the NIH, the actual amount proposed was far below that needed to keep pace with inflation. Particularly worrisome were a plan to limit indirect cost reimbursement on research awards to 90% of negotiated rates, a proposal to eliminate the eligibility of graduate and professional students for Guaranteed Student Loans, and further significant cuts in the Medicare and Medicaid programs. Only the VA came close to holding its own, with a proposed budget level close to its FY 1981 high. To implement his "new federalism" plan, President Reagan proposed to transfer to the states federal responsibility for welfare, food stamps, and various discretionary

programs including some health block grants. In exchange the federal government would assume full responsibility for Medicaid.

The AAMC testified before the House Budget Committee on the President's proposed FY 1983 health budget to describe the scientific, social and economic benefits of biomedical research and warn that while the nation stands at the gates of the "age of biotechnology," it consistently underfunds the very research enterprise that will determine whether it retains preeminence in this important field.

When Congress set to work on the first budget resolution for FY 1983, the stalemates that characterized FY 1982 action reappeared. The Senate Labor and Human Resources Committee was not even able to reach a consensus to transmit recommendations to the Senate Budget Committee.

Ultimately, the Senate approved a three-year freeze on non-military discretionary programs with a small add-on for health research and extensive Medicare and Medicaid reductions.

Passage of the first budget resolution did not meet statutory deadlines. At least six different substitutes for the House Budget Committee's plan, as well as some 70 amendments, were presented. After four days of grueling debate, the House left town for its Memorial Day recess without a budget. On vote after vote, the two political parties and various loose coalitions failed to muster the needed support for any of the proposals. Finally, in mid-June, the House adopted by 13 votes a budget package similar to the Senate version.

The first budget resolution for FY 1983 emerged from conference containing a three-year freeze on non-military discretionary programs, a reduction in Guaranteed Student Loans, and substantial Medicare and Medicaid cuts. A measure of its lack of popularity was that it was approved in the House by a margin of two votes. Nonetheless, its passage sustained the momentum of presidential control of the budget process.

While the Senate moved ahead with a reconciliation measure proposing savings almost as great as were mandated, House action was chaotic. Democrats in the House Ways and Means Committee, anxious to avoid the stigma of increasing taxes or reducing social programs,

prevented Committee action on a comprehensive proposal. The failure of the full House to do more than simply disapprove the Senate proposal, while agreeing to send members to a conference, created a legislative situation in which the House conferees had to act without specific instructions from the body they represented.

Meanwhile, the FY 1983 appropriations process had gotten underway with House and Senate hearings. Testifying before both Subcommittees on Labor/HHS/Education Appropriations, AAMC stressed the importance of increased funding for biomedical research, research training, student aid and health professions special projects. The subcommittees were especially urged to reject the proposed 90% cap on indirect cost reimbursement.

Testimony was also presented before the House and Senate VA Appropriations Subcommittees. AAMC urged the Congress to increase the FY 1983 expenditures for VA medical care and research beyond the maintenance levels advocated by the Administration.

While the funding levels for biomedical and behavioral research were being debated, a significant incursion into appropriations for those activities arose in the form of small business set-aside legislation. Touted as stimuli to economic growth, increased productivity and job creation, small business innovation development acts were introduced early in the Congress. Although the AAMC early opposed the legislation, widespread awareness of the dangers inherent in these measures did not appear until shortly before the Senate vote on S. 881 embodying a 1% set-aside of extramural R&D funds. Testimony endorsed by the Association pointed out to the Senate Small Business Committee that the legislation would mean that rather than judging all applicants for NIH and ADAMHA grant support against a uniform standard of excellence, applicants from small business firms would be protected from competition with the rest of the applicant pool, establishing a dual standard for federal research and development funds at a time of diminishing support. Notwithstanding this argument, the bill passed the Senate unanimously in December.

In the House, several small business set-aside proposals eventually coalesced into a bill, H.R.

4326, mandating a 3% set-aside based on total agency R&D funds. Subsequent to Small Business Committee action, the Association, working with a number of other organizations, but especially closely with the Association of American Universities and the National Association of State Universities and Land-Grant Colleges, evolved a successful strategy to have the House bill sequentially referred to six other committees whose areas of jurisdiction would be affected. Thus, the legislation received what was probably the closest scrutiny of any bill in the 97th Congress. Members began to question its merits, and five of the six committees reported the bill with amendments to exempt specific agencies or substantially modify the set-aside proposal. The Committee on Energy and Commerce proposed an amendment to exempt all health-related research and the Veterans' Affairs Committee reported an amendment that had the effect of exempting the VA.

Although many members of Congress were sympathetic to arguments against the set-aside provision, the fact that it would enable the Congress to satisfy the large and powerful small business constituency without authorizing or appropriating new funds made its appeal virtually irresistible.

AAMC testimony before three House Committees—Energy and Commerce, Science and Technology and Veterans' Affairs—argued against the use of set-aside funds for either basic research or product development. The statements emphasized that a set-aside for basic research was unnecessary in light of small business eligibility for all federal research grant programs and bad public policy as it violated the principle of open competition based on merit. With regard to the use of set-aside funds for product development, the Association argued that federal assistance to bring products to market should more properly take the form of tax incentives, loan guarantees and other mechanisms consistent with the free enterprise system.

Despite the strategy of sequential referrals and the delays and substantial controversy opponents stimulated, the House passed a substitute measure reported by the Small Business Committee that lowered the set-aside from 3 to 1.25% of the extramural budgets of federal agencies. The Senate accepted the House ver-

sion which provided a six year sunset provision and called for a General Accounting Office study of the program. Shortly thereafter the President signed the bill.

AAMC also devoted considerable energy to legislation regarding the use of animals in research. Although no action has occurred in the Senate, the House Subcommittee on Science, Research and Technology held a hearing on a number of bills. The most threatening would have required 30 to 50% of NIH's appropriations for research involving animals to be earmarked solely for the development of alternative research and testing methods.

The Association worked with the Subcommittee staff and succeeded in substantially modifying a long succession of draft bills. However, the proposal finally approved by the Committee still posed serious problems for the research community. H.R. 6829 requires compliance with accreditation requirements estimated to cost \$500 million within 10 years, without authorizing funds to assist institutions in complying. This bill has been referred to the House Subcommittee on Health and Environment where there will be some effort to modify the more onerous provisions.

In a related matter, the Association opposed an Administration proposal to transfer responsibility for inspection of animal facilities to the states and humane societies. Association testimony before the Agriculture Appropriations Subcommittees emphasized the need to retain federal control over such inspection to ensure that federally funded research is conducted under uniform standards. It also pointed out that there is no evidence that the entities cited in the Administration's proposal are authorized, willing or capable of assuming these important responsibilities.

Also in the area of biomedical and behavioral research, a major concern to the Association was legislation to reauthorize the components of NIH and ADAMHA. The House and Senate bills that emerged did more than simply renew expiring legislation and each contained a number of troubling provisions. While the House did not specifically propose the authorization limits for all NIH institutes which generated so much controversy in the last Congress, language in the report accompanying the bill suggested that the issue was far from dead.

The original House bill underwent substantial expansion and modification during the period between its initial introduction and its approval by the Energy and Commerce Committee. Various components of the initial proposal were split off, amended and reintroduced as separate pieces of legislation. Ultimately, the Committee reported out four separate bills.

H.R. 6457, The Health Research Extension Act of 1982, to renew expiring authorities for the National Cancer Institute, the National Heart, Lung and Blood Institute, the Medical Library Assistance Act, and the National Research Service Award program, provided spending ceilings approximately 10% above the Administration's budget request. Although these levels were only 3-5% more than required to keep pace with projected inflation, retaining them through the unusually long series of markups was viewed as a victory in these austere times. Unfortunately, the bill was burdened with spending directives and study requirements in response to pressures from narrow special interest groups unconcerned with the overall health of NIH.

Particularly worrisome was the successful move to provide for a separate institute on arthritis and musculoskeletal diseases. The Association has long opposed creating new institutes because they decrease the flexibility with which the nation's research effort can be administered and establish dangerous precedents for the endless proliferation of narrow disease-specific organizations. Subsequent to acceptance of the arthritis institute amendment, the basis for the Association's latter concern became graphically clear. An immediate, although unsuccessful, attempt to provide for a separate diabetes institute followed and proposals for at least four other institutes are in the wings.

Other troublesome add-ons included provisions for dealing with scientific fraud, on peer review of contracts and intramural research, for a set-aside for the National Center for Health Care Technology, and for the transfer of the National Centers for Health Statistics and Health Services Research to the NIH.

Split off from the original bill were legislation to renew the National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse and a measure to

transfer the National Institute on Occupational Safety and Health to NIH.

Testifying prior to Energy and Commerce Committee action on these proposals, the AAMC vigorously advocated the renewal of existing authorities, but recommended substantially increased authorization ceilings. The Association also urged that the proposed NIOSH transfer include only its research functions and that Congress specifically provide funds for the NCHCT rather than set-aside money from the already beleaguered NIH budget.

On the Senate side, the Biomedical Research Training and Medical Library Assistance Amendments of 1982 emerged with authorizations 3% above the Administration's FY 1983 budget proposals. The bill made some concessions to pressure for statutory mandates related to disease prevention, the peer review system, intramural research issues and the contract process. The Senate's approach used the mechanism of reports to Congress as opposed to the more rigid provisions in the House counterpart bill.

Testifying before the Senate Labor and Human Resources Committee, AAMC expressed reservations about the adequacy of the proposed authorization ceilings, noting that there has been a steady decline in U.S. investment in science, including biomedical science, that appears to be indicative of a retreat in the federal role in basic research.

The absence of provisions in the Senate bill for an arthritis institute was taken as an encouraging sign. However, under considerable pressure to consider the issue, the Labor and Human Resources Committee later held a separate hearing on a bill to establish such a new institute. As S. 1939 steadily picked up sponsors, including the Committee chairman, it became a virtual certainty that the bill would be added to the renewal legislation.

The outlook for student assistance darkened considerably this year. Consistent with the prevailing philosophy of fiscal austerity and the trend toward constriction of the scope of federal assistance programs, capitalization of the Health Professions Student Loan program was funded at half its FY 82 authorized level. The dearth of congressional support was particularly evident in the Senate Appropriations

Committee proposal to terminate HPSL funding. Prospects for future HPSL funding were shadowed by congressional and press attention to HPSL debt collection problems. Following reports that a number of medical school graduates had been delinquent in repaying borrowed funds, the Senate Government Affairs Committee held hearings on the issue. The DHHS followed up by developing a strict HPSL collection policy that threatens to disallow lending by institutions whose students default on their loans at rates in excess of 5%.

The default issue also arose in connection with the Health Education Assistance Loan, Guaranteed Student Loan, and National Direct Student Loan programs. Legislation was introduced to permit recovery of defaulted loans by offsetting the tax refunds of delinquent borrowers.

For the HEAL program, a more serious issue was a proposed restriction on borrowing limits. The Administration undertook to severely curtail the direct lending and loan guarantee activities of the government. HEAL was among programs targeted for credit limitations at a time when estimates of borrowing need were growing rapidly.

Simultaneously, the Administration proposed to terminate the eligibility of graduate and professional students for loans under the GSL program. Addressing a congressional panel on the impact of the President's FY 1983 budget request for higher education, AAMC emphasized that medical students from lower and middle income families have to borrow money from federal sources such as the GSL program if they are to pay for their educational expenses. Although the Congress did not implement this plan, legislation was introduced to increase the GSL interest rate for graduate and professional student borrowers.

In communications with Congress regarding student assistance, the Association emphasized the negative effects that funding reductions, arbitrary borrowing limits, and eligibility restrictions would have on the effort of medical schools to broaden the socioeconomic base of medical school classes. Also asserted was the need to ensure that medical students would be able to pursue their education in the reasonable certainty that assistance would be available

until graduation.

As the 97th Congress winds to a close, several major issues remain unsettled. Appropriation bills are yet to be formulated for the

FY 1983 funding cycle, various NIH and ADAMHA authorities still need renewal, and some further action is likely on animal legislation, at least in the House.

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Working with Other Organizations

The Council for Medical Affairs—composed of the top elected officials and chief executive officers of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Council of Medical Specialty Societies, and the AAMC—continues to act as a forum for the exchange of ideas among these similar but diverse organizations. Among the topics considered during the past year were student financial assistance, prospective Medicare reimbursement, graduate medical education positions, and national health policy.

Since 1942 the Liaison Committee on Medical Education has served as the national accrediting agency for all programs leading to the M.D. degree in the United States and Canada. The LCME is jointly 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 U.S. 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, identifying 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, profes-

sional 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 formal and informal 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 1982 there are 127 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences. Three have not yet graduated their first classes and consequently are provisionally accredited; the 124 schools that have graduated students are fully accredited. Additional medical schools are in various stages of planning and organization. The list of accredited schools is found in the *AAMC Directory of American Medical Education*.

A number of new medical schools have been established, or proposed for development, in Mexico and various 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 schools offer 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 college advisors.

The Accreditation Council for Graduate Medical Education became financially independent this year. Before this, one-half of the operating costs for the ACGME were paid by the American Medical Association. Costs are now covered by revenues generated by charges for the accreditation process.

A memorandum of agreement for the provision of staff services to the ACGME by the

American Medical Association was executed by the five sponsors of the ACGME (Association of American Medical Colleges, American Medical Association, American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies). The past year has seen the accreditation process improved and made more effective.

The ACGME provides the opportunity for residency review committees (RRCs) to accredit programs in their specialty independent of review by the Council. RRCs granted independent accrediting authority must abide by the policies and procedures of the ACGME and submit their procedures and actions to periodic review by the Council. Thus far, ten RRCs have requested and been granted independent accrediting authority.

Additional accrediting responsibility for the ACGME has resulted from the establishment of an RRC in emergency medicine and the approval of the accreditation of subspecialty programs. The policies and procedures for subspecialty program accreditation are being developed.

The revised General Requirements of the Essentials of Accredited Residencies, approved in 1981, became effective July 1, 1982. To assist hospitals and program directors to develop policies and procedures in compliance with the revised requirements, the AAMC co-sponsored regional workshops with the American Hospital Association. The five one-day meetings were extremely well attended and indicated a high level of interest in the implementation of the revised requirements.

The new requirements provide the authority to the ACGME to set the standards for eligibility to enter accredited graduate medical education programs. In May 1982 the ACGME approved revised standards that allow graduates of LCME accredited medical schools and schools accredited by the American Osteopathic Association to enter graduate medical education without further examination or other requirements. However, graduates of schools not so accredited must pass a written examination acceptable to the ACGME for evaluation of cognitive skills. This examination will be required of all candidates wishing to enter accredited graduate medical education pro-

grams regardless of their citizenship. The ACGME noted that the present Visa Qualifying Examination is an example of a satisfactory examination. The Educational Commission for Foreign Medical Graduates has announced that such an examination is in development for implementation in 1984. A proposal by the AAMC that candidates passing that examination be required to pass an evaluation of their clinical skills by direct observation in prepared test centers has been referred to a special ACGME task force to determine feasible methods to accomplish such an evaluation.

The Accreditation Council for Continuing Medical Education continued its efforts to strengthen the accreditation process. Because of some changes requested by the AMA's House of Delegates, the Essentials still await final approval. Nevertheless, the relative simplicity and clarity of this document has aided the decision making process. By streamlining the review procedures and the policy making process, the ACCME was able to reduce the number of required meetings from three to one per year, a strategy which helped keep accreditation and policy costs at a steady level.

In a recent decision the ACCME adopted a definition or interpretation of continuing medical education that should be of interest to physician educators and administrators. According to this policy all educational activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are considered continuing medical education. This would include efforts to improve management practices and teaching abilities of the faculty.

In a drive to apply the new Essentials to the entire continuing medical education accreditation process, ACCME is actively engaged in strengthening its relationships with state medical societies now responsible for accreditation of organizations sponsoring continuing medical education largely for physicians within the state. Criteria and standards by which the ACCME will delegate this accreditation authority are under development.

The Educational Commission for Foreign Medical Graduates has responded positively to demands by the medical community, and notably the AAMC, to adopt a single examination

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for both alien and U.S. citizens who are graduates of foreign medical schools as a requirement for its certification program. A single, two-part examination now being developed jointly by the ECFMG and the NBME will be similar to the present Visa Qualifying Examination required for alien FMGs to obtain a visa. The ECFMG is also exploring various options for assessing the practical patient care skills of graduates of foreign schools either prior to or after acceptance into a graduate medical education program.

In the face of diminishing opportunities and resources for graduate medical education the ECFMG believes that opportunities for the education and training of alien graduates of foreign schools be directed primarily to the development of medical and academic leadership in foreign countries. This may require collaboration with the ACGME in reviewing graduate medical education programs that accept such FMGs.

The Coalition for Health Funding, which the Association joined with others in establishing 12 years ago, has expanded its activities and influence by monitoring and commenting on the development of the congressional budget resolutions in addition to its ongoing efforts on the appropriations process. The unpredictabilities in the evolution of the congressional reconciliation process presented new challenges to the Coalition and emphasized the importance of cooperation among organizations with similar interests. Widespread acknowledgment of the usefulness of the Coalition's annual position on appropriations for the discretionary health programs offers significant evidence of

the respect with which it is held.

The diversity of the Association's interests and the nature of its constituency offer 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 Intersocietal 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 reconciled, and collective actions undertaken in the area of federal legislation and regulation.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with representatives of the educational and professional associations of other health professions. This year FASHP has been especially concerned about assuring adequate student assistance funds through the Guaranteed Student Loan Program, the Biomedical Research Support Grant Program of NIH, and proposed changes in the administration of the Health Professions Student Loan Program. FASHP has also undertaken a major role in publicizing the Secretary's Award for Innovations in Health Promotion and Disease Prevention of the Department of Health and Human Services and will act as a selection committee for choosing finalists in the award program.

Education

The AAMC Teaching Institutes of the late fifties were the last time academic medicine embarked upon a study comparable in character and magnitude to the AAMC General Professional Education of the Physician project. This activity, sponsored by The Henry J. Kaiser Family Foundation, got underway in January when its Advisory Panel held its first meeting. Steven Muller, president of The Johns Hopkins University and The Johns Hopkins Hospital, is chairman of the panel, and William P. Gerberding, president of the University of Washington, is vice-chairman. The panel of eighteen members includes deans and faculty members from universities and colleges as well as medical schools and a private practicing physician. The panel's major goals are to assess the present approaches to the general professional education of the physician and college preparation for medicine and to develop recommendations and strategies to improve the effectiveness of instructional programs for the promotion of learning, and to stimulate broad discussions among the medical school and college faculties and their disciplinary societies about their philosophies and approaches to medical education and college preparation for medicine.

The greatest emphasis is placed on the stimulation of discussion among faculties, for the faculties of colleges and medical schools are ultimately responsible for selecting and teaching what students are expected to learn, and they also are responsible for setting the tone of the learning environment.

Subsequent to the first meeting of the project panel, a stimulus paper was prepared and widely disseminated to individuals responsible for the general education of the physician—the years that include college and medical school education. The response to this document indicated a high level of interest in the project.

The project progressed with the distribution of a booklet describing charges to three GPEP

working groups to the Council of Deans, the Council of Academic Societies, the Council of Teaching Hospitals, the Organization of Student Representatives, the Group on Student Affairs, and the Group on Medical Education.

One GPEP working group, chaired by John Gronvall, University of Michigan Medical School, will consider the essential knowledge that all students should acquire during their general professional education. The group chaired by Victor Neufeld, director of the M.D. Programme, Faculty of Health Sciences, McMaster University, will consider those skills that all students should acquire during college and medical school to gain essential knowledge. The team led by Robert Kellogg, dean of the College of Arts and Sciences, University of Virginia, will describe the personal qualities, values, and attitudes that all physicians should possess. These GPEP working groups will meet during the next academic year.

Concurrently, 81 U.S. and Canadian medical school deans will organize institutional discussions by faculty, hospital staff, and students on the topics being considered by the working groups. In a corollary effort, 18 CAS professorial societies have organized disciplinary discussions on these subjects. Through these activities a broad range of those interested in medical education can engage in dialogues that will parallel those of the three working groups. Selected four-year colleges and universities will also participate in this phase of the project, which will conclude in May 1983. This three-year project will extend through the Association's 1984 annual meeting where a final report will be presented.

The GME has from the outset made a significant commitment to the GPEP project. Its 1981 spring regional meetings dedicated significant time to assisting in the identification of issues and alternate strategies for the emerging project. These were refined at sessions during the 1981 annual meeting and formed the basis

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for the report of its chairman to the GPEP panel at its second meeting. Members of the GME next see a role in facilitating local faculty consideration of the "Charges to the GPEP Working Groups," in preparing an institutional response, and in providing special comments both organizationally and individually as a community of educational scientists and persons with day-to-day responsibility for the management of the educational program.

The GME will join with the GSA at the 1982 annual meeting in a discussion of the social, economic and political pressures affecting medical education. Issues that will be discussed include barriers to admission, impact on career development, influence on curriculum management, and the effect on faculty roles in the basic and clinical sciences. These and other topics will be treated in the educational exhibits, the miniworkshops, the small group discussions, and the RIME papers and symposia.

The importance of linking improved quality of education to improved quality of patient care is at the core of the planning for intensified activity by the GME in continuing education. Sessions scheduled for the annual meeting concentrate on this goal by seeking ways to improve ties between the academic and practice communities and by considering approaches for incorporating principles of geriatric care in continuing education programs.

The RIME conference has been cited as a barometer of the level and kinds of concerns existing in the community. If this is valid, then the level of interest has intensified with the largest number of papers ever submitted being recorded for the 1982 conference. Admission to medical school, choice of residency and selection of residents, and needs assessment and program evaluation in continuing medical education were the areas of heaviest concentration.

Work has continued in the AAMC Clinical Evaluation Project. Staff has prepared a summary statement and accompanying background report on "Basic Issues in the Evaluation of Clerks and Residents: Perceptions of Clinical Faculty." These documents will be the basis for working with clinical faculty to enhance their understanding of issues in the evaluation of the performance of clerks and resi-

dents. They will also help to identify strategies for implementing the suggestions for change that emerge. The issues and proposals contained in these materials were generated from the responses of clinical faculty from over 500 departments and have been tested in a series of site visits. The next phase is the development and refinement of specific materials that will support efforts to improve the evaluation of clinical skills.

The MCAT Interpretive Studies Program, a cooperative effort with 30 member schools, continued to gain momentum. Several schools reported on their activities during the 1981 annual meeting. Most of the results discussed concentrated on performance criteria obtained during the first two years of medical school. Emphasis has subsequently shifted to the identification of appropriate measures of clinical performance information. A summary was presented at each of the regional meetings of the GSA and at a symposium sponsored by the American Educational Research Association.

Meanwhile staff and contractor efforts to monitor and enhance MCAT test quality continued. A study of the content relevance of the science material on the test was completed, and a major project to explore subgroup performance differences was designed and initiated.

Along with these specific projects to improve quality, the Association continued its efforts to preserve the integrity of the test program from destructive governmental regulation. The AAMC continues its complaint against the state of New York in federal court and continues to offer the MCAT in New York only under the protection of a preliminary injunction. New York remains the only state to have passed such restrictive legislation. At both the federal and state levels a significant decline in interest in testing legislation was noted. This trend was supported by the report of the Committee on Ability Testing of the National Academy of Sciences, which found no justification for recommending governmental regulation of testing in either educational or industrial settings.

The continuing education systems project is now working with a number of institutions and organizations to test the validity and usefulness of the concepts and criteria of quality for improving the continuing medical education pro-

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ess. The products developed in this project have been helpful to other organizations developing their own procedures for assessing and improving the quality of their continuing education programs, including the Temple University Continuing Medical Education Consortium, the California Medical Association, the American Red Cross, the American Association of Dental Schools and the Veterans Administration. Other institutions are interested in changing particular aspects of the continuing education programs of their colleges. To strengthen this input, the continuing education systems project has now completed the preparation of manuscripts on needs assessment, program development and evaluation, and on promoting self-directed learning in continuing medical education. These learning packages will be produced by the Learning Resource Center of the Salt Lake City Veterans Administration Medical Center.

A seven-year collaborative project of the AAMC with the National Library of Medicine has concluded. During these years the AAMC assisted the NLM in developing AVLINE as an on-line, comprehensive data base for audio-visual educational materials. The dimension and significance of the data base were enhanced by a critical review process that engaged over 2,000 faculty members in the review of catalogued items. While NLM is continuing the AVLINE data base, it has discontinued its support for the critical review process. This

represents a loss to those in health professions education, who consider the establishment of discriminating data bases an important step towards realizing the future role of the medical library as an information center.

At the end of 1981 the Association undertook a new project to increase the understanding by officials and faculty of medical schools and teaching hospitals of the impact of the aging population on medical education and the delivery of health care. As its first effort the Steering Committee for the project developed a discussion draft describing the attitudes and basic and clinical sciences knowledge that should be included in undergraduate medical education. This discussion draft was reviewed by participants at four Regional Institutes on Geriatrics and Medical Education held in spring 1982. Representatives from 88 percent of U.S. medical schools attended these sessions, which also featured small group discussions about models for geriatrics programs already in place in some medical schools. The Steering Committee and its consultants revised the document, "Educational Preparation for Improved Geriatric Care," after the discussions at the Regional Institutes. The project will conclude with a special general session at the 1982 AAMC Annual Meeting and the publication of the proceedings of the four Regional Institutes. This effort has been supported by the Pew Memorial Trust and the National Institute on Aging.

Biomedical and Behavioral Research

Along with the other agencies of the Department of Health and Human Services, the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration functioned for the third consecutive year without a formal appropriations law. The final continuing resolution for fiscal year 1982, passed by Congress in March, provided a level of funding sufficient for the NIH to support approximately 4,700 new and competing research project awards compared with 5,100 in fiscal year 1981. The ADAMHA budget supported approximately 214 new and competing project awards compared with 336 in 1981. The drop in the percentage of approved grants funded by NIH to below 35 percent has caused major concern in the academic community. In research training, the NIH supported approximately 9,700 trainees under the National Research Service Award program in FY 1982 compared with 10,700 in 1981 and ADAMHA supported approximately 1,070 trainees compared with almost 1,400 trainees in 1981. Allowances to the institutional sponsors of research training were reduced by 50 percent. The research programs of the Veterans Administration have also been constrained as the result of an 8.5 percent reduction in funding. The outlook for the 1983 federal research budget is not cause for optimism. The Reagan Administration's proposal to reimburse only 90 percent of negotiated indirect costs associated with re-

search grants would considerably erode the institutional base that supports research. There is understandable concern in the academic community that continued retrenchment discourages aspiring young scientists from the pursuit of careers in research.

The AAMC, with the endorsement of the Executive Council, has entered into the first phase of a national public relations campaign to heighten public awareness about the benefits to society of biomedical and behavioral research. More than 130 academic medical societies and voluntary health groups have been invited to participate in these activities. Their response has been overwhelmingly favorable. The Association has retained the services of a public relations firm to assist in developing a public relations strategy and the preparation of materials to be used in the solicitation of funds to support the campaign. After the strategy has been developed medical schools and teaching hospitals will be provided with core public relations materials that can be used to augment their local and regional activities. It is hoped that the public relations campaign can begin about January 1, 1983, and can be conducted at both the national and local levels during the year, building to a culmination in the fall of 1983 with either a presidential or congressional proclamation of a National Medical Research Month.

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Health Care

The federal government has forecast that the number of Americans 65 and over will increase from 25 million in 1980 to 36 million in the year 2000 and 65 million by 2030. Within this population, the number of people 80 and over is projected to increase even more dramatically—nearly doubling from 5.2 million in 1980 to 10 million by 2000. This group, often referred to as the “old-old,” is more likely to need long term care due to a heightened risk of chronic diseases or conditions or multiple health and social problems that limit their capacity for self-care. Long term care for such functionally impaired elderly encompasses a wide range of health and social services to prevent further disability, maintain current levels of function, and restore capabilities that have been lost.

The implications of these demographic trends on the costs and utilization of health and social services are staggering. However, these considerations are but one of several areas of concern regarding the future of long term care. Other currently recognized problems include fragmentation and lack of coordination of services, insufficient and inadequately trained health and social services providers, limited knowledge about aging processes and specific diseases and conditions affecting the elderly, and a paucity of community-based services to counter an overreliance on institutionalization.

During the past year, under a two-year cooperative agreement with the Administration on Aging, the AAMC continued to provide technical assistance to a group of Long Term Care Gerontology Centers. The centers are based in or affiliated with medical schools, and have been awarded grants for research, development of education and training programs and service models, information dissemination and technical assistance to address many of the problems in long term care.

Under the AoA-sponsored project, AAMC staff have identified field consultants to assist

centers in both early and advanced stages of planning, conducted three workshops to address common organizational problems and suggest strategies for improving coordination among the centers, and developed a management information system to gather aggregate data on the centers' activities for AoA. Through newsletters, workshop reports and *ad hoc* information memos, the AAMC staff have also disseminated information on the research, education and training, and service models of the LTCGCs. In addition, a two-volume annual report described the collective accomplishments of the first five operational Long Term Care Gerontology Centers.

During the past year, the proceedings were published for a national conference co-sponsored by the AAMC and the Henry J. Kaiser Family Foundation on affiliations between academic medical centers and health maintenance organizations. The benefits and risks to both parties to these affiliations were explored. Case histories described various forms of prepaid practices, the different relationships that can exist, and the organizational, financial and educational considerations associated with these affiliations. *Health Maintenance Organizations and Academic Medical Centers*, available from the Kaiser Family Foundation, contains the major conference presentations and summaries of the participant discussions. This volume adds substantially to the body of knowledge on affiliations between prepaid plans and academic medical centers. In addition, three broad conclusions are made: there is a need for resources to support medical education in prepaid practice settings; large tertiary care hospitals will increasingly compete with secondary care community hospitals for prepaid practice patients; and relationships in which medical centers and HMOs retain a high degree of independence are advantageous to both types of organizations.

In related activity, the Association, in con-

junction with the Department of Community Health of the Tufts University School of Medicine, currently is conducting a survey to identify the extent of undergraduate clinical medical education involvement at prepaid health care plans and the methods and data used to analyze the costs associated with medical education in these settings. This information is being sought in light of the pressures to expand prepaid health care plans and the growing interest of academic medical centers in this method of delivering medical services.

The teaching of quality assurance and cost containment to undergraduate and graduate medical students and allied health professionals was the focus of two AAMC-prepared publications released in October 1982. The texts, *Quality Assurance and Cost Containment in*

Health Care: A Faculty Guide and Principles of Quality Assurance and Cost Containment in Health Care: A Guide for Medical Students, Residents, and Other Health Professionals, offer faculty and curriculum planners numerous suggestions on facilitating the introduction of cost containment and quality assurance instruction into medical education and provide excellent materials for self-instruction. They also provide a systematic five-stage approach to conducting quality assurance and cost containment studies, using a methodology analogous to the stages of the clinical management of patients. In addition, the detailed case histories presented on quality assurance and cost containment studies conducted in actual delivery settings illustrate how the concepts and theories presented can be applied in practice.

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Faculty

The leadership of the Association of American Medical Colleges has long been interested in broad issues of concern to faculty in the realm of scholarship, pedagogy, research, and research training. Research training for physician faculty, the apparent decline in the number of physicians entering research careers, and the difficulty of Ph.D. biomedical scientists in securing appropriate academic appointments are some of these concerns. To illuminate these problems, a number of relevant studies have been performed by the Association, sponsored by the National Institutes of Health and the National Academy of Sciences.

A study reported in March 1982 tested the conventional assumption that the majority of physicians engaged in research are members of medical faculties. Using the Association's Faculty Roster and the membership lists of twenty-four selected professional biomedical research societies, it was found that two-thirds of the physician members are now or were at one time on medical school faculties. On the other hand, more than half of the faculty members reported to the Roster as being engaged in research were not members of any of the twenty-four societies, even though a broad spectrum of research oriented societies was chosen, including all of the non-disciplinary general interest societies. Results of the study were distributed to presidents of CAS members, the NIH, and the Committee on Biomedical and Behavioral Research Personnel of the National Academy of Sciences.

Another study reviewed the increasingly common practice of appointing Ph.D.s in clinical departments. The growth in opportunities in clinical departments comes at a time of diminishing appointments in the basic science departments. A surprising finding was that in 1978-79 more Ph.D.s were added in clinical than in basic science departments. In the aggregate, Ph.D.s in basic science departments outnumber Ph.D.s in clinical departments by only a little more than four to three.

The Faculty Roster System, initiated in 1966, continues to be a valuable data base, containing information on current appointment, employment history, credentials and training, and demographic data for all full-time 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 completing questionnaires for other organizations, for identifying alumni serving on faculties at other schools, and for producing special reports. As of July 1982, the Faculty Roster contained information on 49,285 full-time salaried faculty and 1,837 part-time faculty. The system also contains 46,875 records for persons who previously held a faculty appointment.

Based on the Faculty Roster, the Association maintains an index of women and minority faculty to assist medical schools and federal agencies in affirmative action recruiting efforts. Approximately 300 recruitment requests from medical schools have been filled by providing the records of selected faculty meeting the requirements set by search committees. The only faculty records utilized in this service are those for individuals consenting to the release of their information for this purpose.

The Faculty Roster was also used to produce a report on the participation of women and minorities on U.S. medical school faculties in 1982.

The Association's *1981-82 Report on Medical School Faculty Salaries* was released in February 1982, presenting compensation data for 119 U.S. medical schools and 31,619 filled full-time faculty positions. The tables present compensation averages, number reporting, and percentile statistics by rank and by department for basic and clinical science departments. Many of the tables also allow comparisons according to type of school ownership, degree held, and geographic region. The periodic *Report on Medical School Faculty Fringe Benefits* was issued in July 1982.

Students

As of September 3, 1982, 35,548 applicants had filed 332,997 applications for the entering class of 1982 in the 127 U.S. medical schools. These totals, although not final, represent a 3 percent decrease in the national applicant pool in comparison to the September figures for the 1981 entering class.

First-year enrollment increased from 17,186 in 1980-81 to 17,268 in 1981-82, while total enrollment rose from 65,189 to 66,298. Although the actual number enrolled is the largest ever, the 1.7 percent increase in total enrollment represents the smallest growth in the past ten years.

First-year enrollment of women medical students reached 5,317, a 7.1 percent increase since 1980-81, and the total number of women enrolled was 18,505, a 7.3 percent increase. Women held 27.9 percent of the places in the nation's medical schools in 1981-82 compared to 22.4 percent five years earlier.

First-year enrollment of underrepresented minorities equaled 1,671 or 9.7 percent of the 1981-82 first-year class; the total number of underrepresented minorities enrolled was 5,503 or 8.3 percent of all medical students enrolled in 1981-82.

The application process was facilitated by the Early Decision Program. For the 1982-83 first-year class 971 applicants were accepted by 68 medical schools offering such an option. Since each of these applicants filed only one application rather than the average of 9.5 applications, the processing of approximately 8,250 additional applications and scores of joint acceptances was avoided. In addition, the program allowed successful early decision applicants to finish their baccalaureate programs free from concern about admission to medical school.

Ninety-eight medical schools participated in the American Medical College Application Service to process first-year application materials for their 1982-83 entering classes. In ad-

dition to collecting and coordinating admission data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admission, matriculation and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Student Affairs Steering Committee.

The Advisor Information Service circulates rosters and summaries of applicant and acceptance data to subscribing health professions advisors at undergraduate colleges and universities. In 1981-82, 246 advisors subscribed to this program.

During each application cycle, the AAMC investigates the application materials of a small percentage of prospective medical students with suspected irregularities in the admission process. These investigations, directed by the AAMC "Policies and Procedures for the Treatment of Irregularities in the Admission Process," help to maintain high ethical standards in the medical school admission process.

The number of Medical College Admission Tests administered decreased 1 percent in 1981 from 49,646 the previous year. The decrease is more pronounced in the number of individuals sitting for the test for the first time. In 1981 there was a 5.6 percent decrease in first-time examinees while the number of repeating examinees increased by 9.8 percent. For the period 1978-81 the number of first-time examinees has decreased 11.7 percent accompanied by an 11.4 percent net increase in repeating examinees. Male examinees continue to represent a smaller proportion of the examinee group with decreases in 1981 occurring in both the number of first-time and repeating examinees. Although the percent of women examinees increased, the number of first-time women examinees actually decreased by 2.5 percent in 1981; the number of repeating women examinees increased by 14.5 percent over 1980.

The Medical Sciences Knowledge Profile ex-

amination was administered for the third time in June 1982 to 2,078 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC in the evaluation of individuals seeking advanced placement. While 5.2 percent of those registering for the test have degrees in other health professions, 87 percent of all registrants were currently enrolled in a foreign medical school. The total number of examinees for the 1982 administration was 300 greater than in 1981.

Efforts continued to sustain the availability of financial assistance for medical students and to enhance the administrative expertise of medical school financial aid officers. Attempts by the 97th Congress to pass legislation that would impact on the substance and funding levels of federal financial aid programs available to medical students were carefully monitored. Testimony and written comments were delivered at each appropriate opportunity. Two workshops to improve the administration of financial aid at schools of medicine, osteopathy and dentistry were held during 1981-82. The grant from the Robert Wood Johnson Foundation supporting this activity will conclude with a program in Philadelphia November 17-19, 1982. The Association has also surveyed all medical schools about any innovative and successful student financing strategies and is exploring possible new sources of capital for student aid from the private sector. The Health Professions Student Loan program debt collection activities by the schools became a major issue. The Association worked closely with the schools and the Department of Health and Human Services to reduce the rate of delinquencies in the HPSL program.

The AAMC received a Health Careers Opportunity Program grant from the Department of Health and Human Services, Office of Health Resources Opportunity for three types of workshops to improve and develop effective programs for the recruitment and retention of students underrepresented in medical education. The Simulated Minority Admissions Exercise Workshop is for medical school personnel concerned with the admission and retention of minority students. The Retention and Learning Skills Workshop assists medical school per-

sonnel concerned with academic performance and retention of minority students. The Minority Student Financial Assistance Workshop is directed to student financial aid program administrators, financially disadvantaged students and premedical advisors to develop efficient and effective administration of financial aid programs. Additional workshops are planned for 1982-83.

The annual medical student graduation questionnaire was administered to the class of 1982 in 121 of the 123 medical schools with seniors. Approximately 11,000 students participated in the survey, a response rate of 67 percent. A summary report comparing national responses with individual institutional data was mailed to each school in September. Selected results appear in the 1982 directory of the National Resident Matching Program.

The Graduate Medical Education Application for Residency, developed by the AAMC at the recommendation of its Task Force on Graduate Medical Education and distributed by the National Resident Matching Program, was employed for the second year. Applications were disseminated along with NRMP materials to medical school student affairs offices for use by students entering residency programs. The universal application facilitates the process of applying for a residency position by providing a standard form for transmittal of basic information from students to hospital program directors. Program directors may request supplemental information from applicants.

The inclusion in the "Recommendations of the AAMC Concerning Medical School Acceptance Procedures" of a provision that all schools offer sufficient places to fill their first-year classes by May 15 of each admission cycle was well received. This strategy to lessen the tension for both schools and students produced by the acceptance of large numbers of students during the summer months was used by virtually all schools in 1981-82.

The Group on Student Affairs-Minority Affairs Section continued to implement the recommendations of the AAMC Task Force on Minority Student Opportunities in Medicine. A major activity of the GSA-MAS was the Medical Careers Awareness Workshop for minority students. The workshop, held during the

1981 AAMC Annual Meeting, attracted over 200 student participants. Forty-one medical schools were represented. In addition, the GSA-MAS has planned projects in the areas of external examinations, graduate medical education, and faculty development.

Substantial progress was made on *U.S. Med-*

ical Students, 1950-2000: Trends and Projections, with continued support from the Commonwealth Fund. A four-round Delphi Survey on the characteristics of future medical students was completed in December 1981 and will be incorporated in the book. Publication is scheduled for 1983 as part of the new AAMC Series in Academic Medicine.

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Institutional Development

This year marks the tenth anniversary of the Association's Management Advancement Program, an effort to strengthen the management capabilities of medical school and academic medical center personnel. MAP continues to develop and conduct educational seminars, to analyze management issues, and to assist in identifying appropriate consultant services. To date fifty-four seminars have been offered; participants from 125 U.S. and 13 Canadian medical schools and 146 teaching hospitals have participated.

The program assists 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.

Again this year, emphasis has been placed on executive development seminars for senior academic medical center administrators, an intensive week-long seminar on management theory and technique. During the 1981-82 year there were three executive development seminars offered to medical school department chairmen. Participants included chairmen from departments of anesthesiology, medicine, obstetrics/gynecology, ophthalmology, orthopaedic surgery, pediatrics, psychiatry, and surgery. For the second consecutive year, a seminar focusing on the academic medical center/VA medical center affiliation relationship was conducted for VA medical center deputy directors as part of their professional development program. This program was sponsored with the Veterans Administration central office. Executive development seminars for deans, teaching hospital directors, and medical school depart-

ment chairmen are planned for the coming year.

The Management Advancement Program was planned by an AAMC Steering Committee. Faculty from the Sloan School of Management, Massachusetts Institute of Technology, have played an important role in the selection and presentation of seminar content. Consulting expertise has been provided by many individuals including faculty from Harvard University Graduate School of Business Administration, the University of Oklahoma College of Business Administration, the Brigham Young University, The University of North Carolina School of Business Administration, the George Washington University School of Government and Business Administration, and the Wharton School of the University of Pennsylvania. Initial financial support for the program came from the Carnegie Corporation of New York and the Grant Foundation. Funds for MAP implementation came primarily from the Robert Wood Johnson Foundation. The program is now supported by the Association and through conference fees.

In 1976 the Management Education Network was designed to identify, document, and transmit management information relevant to medical center settings. Supported by the National Library of Medicine, products from the MEN project include a study guide and companion audio-visual tapes on strategic planning, a study on medical school departmental review, a simulation model and companion study on tenure and promotion in academic medical centers, and a final report of the study of academic tenure.

In May 1982 the AAMC completed a two-year study sponsored by the National Library of Medicine. The report, entitled *Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management*, was approved by the Executive Council and published as a supplement to the *Jour-*

nal of Medical Education. The study involved site visits to ten institutions, meetings with many groups of health sciences librarians, an extensive review of the literature and the analysis of data from several surveys. William D. Mayer, M.D., president of the Eastern Virginia Medical Authority, chaired a nine-member advisory committee.

This is the fourth in a series of AAMC reports sponsored by the NLM to improve the quality of academic information management and transfer in academic medical center libraries. The report provides medical center administrators with a perspective on the electronic information transfer environment and the trends likely to affect the management of academic information by faculties, staffs, and students in medical centers. It is suggested that medical centers are poorly positioned to function effectively in an electronics-dominated, information-based society. A rationale for the long-range development of integrated institutional information networks is given. A series of scenarios describes the effects of newer information technologies on the flow of information and their uses by faculty members, staff and students. Two types of technologically sophisticated libraries are described. An argument is made that libraries can play a leadership role in introducing integrated information management networks into medical center settings.

Recommendations are addressed to three groups that will need to work together to bring

about necessary changes in a timely fashion. Academic medical centers are called on to take the first steps towards information networks by strengthening the technological capabilities of their libraries. Professional bodies are asked to assist medical centers to strengthen the interactions among education, research, and patient care through the incorporation of innovative information transfer systems into those processes. Public and private agencies are asked to share responsibilities for the costs of developing and supporting state-of-the-art information technologies to ensure a quality world biomedical information base.

Also completed and published in the fall of 1982 was a study titled *The Management of Information in Medicine: An Assessment of Applications of Technology, Policy Consequences, and Needed Changes in the Present System.* This study, sponsored by the Josiah Macy, Jr. Foundation, had three goals: an assessment of technological developments in information management applicable to the academic medical center functions of medical education, research, and patient care and to the managerial functions which permit accomplishment of the tasks of the organization; the formulation of assumptions about the impact of future information management technological developments; and the identification of major policy issues for institution decision-making relating to the developments and changes needed in the present systems for managing information in light of likely developments in the area of information technology.

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Teaching Hospitals

The Association's teaching hospital activities were concentrated on the Budget Reconciliation Acts of 1981 and 1982, proposed tax-exempt financing restrictions, health care competition, health planning, legislative and regulatory analyses, a major study of teaching hospital characteristics, and surveys and publications.

In August 1981 President Reagan signed the Omnibus Reconciliation Act of 1981, mandating overall federal spending reductions, including \$9 billion from the health component of the budget, through sweeping changes to both discretionary and entitlement programs. In relation to Medicare and Medicaid changes with potential impact on teaching hospitals, the positions advocated by the AAMC were supported on three critical issues. Despite considerable pressure from the Administration, the congressional conferees rejected a "cap" on Medicaid payments to the states. Instead, federal matching payments were reduced by specified percents in FY 1982 through 1984. However, several factors could decrease the costs in individual states. The House-Senate conferees also agreed to delete a House proposal requiring that interest earned on funded depreciation be offset against interest paid on capital indebtedness. In addition, separate rates for hospital-based and free-standing facility dialysis were required.

Enacted Medicare provisions included a reduction of the routine nursing salary differential to no more than 5%, a reduction of the section 223 ceiling for reimbursement of inpatient routine hospital costs, a limitation on the reasonable costs or charges for hospital-based outpatient services, and a requirement that HHS assess the performance of Professional Standards Review Organizations.

Strong support from the leadership of the Democratic Party and vigorous lobbying efforts by President Reagan enabled Congress to pass the "Tax Equity and Fiscal Responsibility Act

of 1982" on August 19. Several spending reductions for the Medicare program are contained in this legislation, including elimination of the routine inpatient nursing cost differential, expansion of the limits imposed on routine hospital costs (section 223 limits) to screen ancillary service costs as well as routine costs on a per case basis, and the creation of a second limit on hospital expenditures called a "target rate," under which hospitals will be severely penalized for exceeding the target or can share in the savings if their costs are reduced below the target. Payment to hospital-based physicians also will be curtailed under this law, and payments for physicians assisting at surgery are prohibited in hospitals with an approved residency program in the appropriate surgical specialty except under special circumstances.

Early in the FY 1983 federal budget process, the AAMC wrote to President Reagan to strongly oppose a proposal to cut \$950 million from entitlement programs through across-the-board reductions of 2% in Medicare hospital reimbursement and 3% in federal payments for optional services under Medicaid. The Association argued that these proposals would have a particularly adverse impact on the nation's academic medical centers and teaching hospitals, which provide a large proportion of care for the poor and the elderly. Responding to such opposition and to concerns about the potential for increased cost-shifting to private paying patients, congressional committees abandoned both proposals.

The AAMC's opposition to tax-exempt bond limits began even before the Administration submitted its budget request. Responding to remarks by Treasury Secretary Donald Regan, the Association wrote to request that the use of tax-exempt bonds by non-profit hospitals be continued. The AAMC joined with the Association of American Universities, the National Association of State Universities and Land-Grant Colleges, the National Association of

Independent Colleges and Universities, and other higher education organizations to oppose restricting eligibility for both hospitals and educational entities. Key Congressmen were alerted about the devastating impacts that the proposed bond restrictions would have on non-profit hospitals, higher education and students. They were urged to reject the Administration's position and endorse existing law regarding 501(c)(3) organizations and student loans in relation to tax-exempt bond use. This position was essentially contained in the tax reform legislation.

Several proposals to stimulate competition in the financing and delivery of health care were introduced in Congress during the past year. Although revenue savings from a health care competition proposal have been projected in the budget request submitted by the President both this year and last, no formal legislation has been proposed by the Administration.

In October 1981, the Association testified to the House Ways and Means Health Subcommittee on the major "pro-competition" bills. The Association emphasized that "it is important to remember that there has been no wide-scale experience with these approaches. This is particularly significant because the proponents of price-competition among hospitals have not addressed the potential implications of these approaches for certain types of providers, patient populations, and the nation's supply of trained health manpower." For the teaching hospital to compete in a price-dominated marketplace, the Association explained that proposals would have to address funding for charity care patients and funding for the unique societal contributions of teaching hospitals, including the clinical component of undergraduate education, technology transfer, community-wide tertiary care services, and primary care ambulatory services in medically underserved areas.

Throughout the year, AAMC staff worked closely with the staff of Representative Richard Gephardt to find ways to address the teaching hospital's unique societal contributions within his "pro-competition" measure. At the request of the Congressman's staff, the AAMC obtained from the American Hospital Association's 1981 annual survey of hospitals an anal-

ysis of the charity and bad-debt deductions for the nation's short-stay, non-federal hospitals. The results were startling. Of all such hospitals in 1980, 5.6% (327) were non-federal members of the Association's Council of Teaching Hospitals. These COTH hospitals incurred 47% (\$601 million) of the charity care deductions and 35% (\$1.2 billion) of the bad-debt deductions for those hospitals. These data provided a clear measure of the special societal costs borne by teaching hospitals and underline the Association's concern that consumer choice/price competition proposals for restructuring health services pose a special risk for teaching hospitals unless improved financing is obtained for patients unable to pay for care. This concern, as well as others presented in the Association's earlier testimony before the House Ways and Means Health Subcommittee, was voiced again by the AAMC at hearings conducted by the National Council on Health Planning and Development on "The Role of Health Planning in a Pro-Competitive Health System."

The position statement developed by the *ad hoc* Committee on Health Planning was approved by the Association's Executive Council in April 1982. In it the Association supported the concept of community-based health planning in an entirely new streamlined federal health planning law. The new statute should encourage the continuation of local health planning on a voluntary basis and mandate state certificate of need review at levels higher than in current law. The Association would not oppose limited federal technical assistance funding for the voluntary local planning component. Compliance with the CON mandate would require establishment of state legal authority for CON review and development of a state health plan, and would be enforced through withholding federal payments under certain health block grant programs. In addition, the revamped program must continue to give special consideration to the unique roles and needs of medical schools and teaching hospitals in fulfilling their patient care, education and research missions.

By May the AAMC had become a member of a coalition to promote a revised health planning program. This coalition worked to develop

compromise legislation that would have broad bipartisan congressional support and be acceptable to the Administration. After extensive negotiation, a compromise measure was developed which would repeal the current planning law and establish a health planning block grant in its place. States choosing to receive planning block grant funds would be required to develop state health plans and perform certificate of need review at thresholds higher than in present law.

During the year the Association responded to several proposed regulations or policy changes that would affect teaching hospitals participating in Medicare and Medicaid. The AAMC commented to the Health Care Financing Administration opposing a proposed rule to eliminate a regulation requiring states to announce Medicaid reimbursement changes 60 days before implementation. It was feared that the proposal would permit states to change Medicaid reimbursement without prior notification to providers. The Association felt it would be unfortunate if opportunities for public comment were eliminated solely to expedite administrative affairs and relieve short-term budget constraints.

The Association commented on a proposed revision to the *Medicare Provider Reimbursement Manual*, taking issue with proposed language to redefine seed money grants to include contributions only when they pertain directly to patient care services, establish a new provider, or enable an existing provider to furnish a new health care service. The Association urged that seed money contributions be allowed to assist any hospital operation in which Medicare shares in the allowable costs. It was emphasized that seed money contributions should also be allowed for establishing new residency programs and expanding existing patient care services. The Association also commented on a proposed "clarification" issued by HCFA for sections of the *Provider Reimbursement Manual*. The so-called clarification was believed to actually constitute a major substantive change in HCFA policy by eliminating payment to hospital associations for start-up monies invested in new membership service programs to reduce hospital costs. It was noted that such programs have included centralized

purchasing services, group warehousing, management engineering consulting, combined laundry, and malpractice insurance activities. To avert a substantial barrier to such cost-effective innovations, the AAMC strongly recommended that HCFA withdraw its proposed changes.

In April 1982 the Association responded to regulations proposed by HCFA to establish a prospective payment rate for maintenance dialysis under Medicare's End-Stage Renal Disease program. These prospective payment rates would apply for such dialysis furnished at home or in a hospital-based or independent dialysis facility with rates paid to hospital-based facilities at a slightly higher level. In comments submitted to the HCFA administrator and the House Ways and Means Subcommittee on Oversight, the AAMC emphasized the impact of the proposed payment regulations on teaching hospitals. The Association urged the subcommittee to recommend that HCFA suspend its plan to implement the proposed regulations until it developed a methodology for hospital-based dialysis which used up-to-date, accurate data and which accounted for the particular needs of hospitals and their patients.

On another occasion the Association wrote to HCFA on proposed revisions to the rules governing Medicare and Medicaid survey and certification of health care facilities. While applauding HCFA's efforts to simplify and streamline these regulations, the AAMC identified three areas in the proposed regulations where changes could further avoid unnecessary regulation, duplication and expense. It recommended that survey cycles should not be different for hospitals and their extended care facilities and nursing homes; that the confidentiality of hospital accreditation survey information be extended to their intermediate care and skilled nursing facilities; and that Joint Commission on Accreditation of Hospitals accreditation of providers be accepted for certification in both programs.

For the past two years AAMC staff has studied the characteristics of 33 members of the Council of Teaching Hospitals. The study provides a quantitative description of contemporary teaching hospitals. Under the guidance of the AAMC Committee on the Distinctive Char-

acteristics and Related Costs of Teaching Hospitals, the first two of three study reports were published in 1982. *The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report* presented data on patient case mix in 24 of the study hospitals using the "diagnosis-related groups" methodology developed at Yale University. *The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report* presented data on patient case mix in the same study hospitals using the "disease staging" methodology developed by Joseph Gonella of Jefferson Medical College and others. Considerable time has also been devoted by the AAMC staff to drafting the final project report, which will include data on patient case mix, educational programs, facilities and services, research, hospital staffing, and financing of the participating hospitals.

Among *ad hoc* activities during the past year, the Association surveyed the Medicare documentation experiences of COTH members under the requirements of section 227 of the 1972 Medicare amendments which established spe-

cial payment provisions for physicians' services provided in teaching hospitals. Additionally the AAMC evaluated proposed revisions to the medical staff chapter of the Joint Commission on Accreditation of Hospitals' *Accreditation Manual for Hospitals*.

The *COTH Report*, a comprehensive teaching hospitals issues-oriented newsletter, was published ten times during the past year. In addition to the newsletter, the Association maintained its program of regular membership reports and surveys. *The COTH Directory of Educational Programs and Services* was published for the 14th consecutive year, providing an operational and educational program profile of each COTH member. Other annual teaching hospital survey reports included the *COTH Survey of Housestaff Stipends, Benefits, and Funding*; the *COTH Executive Salary Survey*; and the *COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data*. Data extrapolated from these survey reports were included in datagrams appearing in the *Journal of Medical Education*.

Communications

The Association continues to make its views, studies and reports known to its constituents, federal officials and the general public with a variety of publications, news releases, memoranda and personal interviews with members of the news media. The AAMC responds to many and differing news media inquiries each day in addition to the news stories it generates. The Association report on "The Maintenance of High Ethical Standards in the Conduct of Research" has stimulated considerable media attention in both the lay and scientific press.

An important publication of the Association is the President's *Weekly Activities Report*, published 43 times a year and read by more than 7,500 individuals. It reports on AAMC activities and federal actions which directly affect medical education, biomedical research and health care.

The *Journal of Medical Education* in fiscal 1982 published 1,018 pages of editorial material in the regular monthly issues, compared with 1,045 pages the previous year. The published material included 84 regular articles, 64 communications, and 6 briefs. The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine. The *Journal's* monthly circulation averaged about 6,500, the same as in fiscal 1981.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1981-82 totaled 413, compared with 421 the previous year. Of the 413 articles received in 1981-82, 144 were accepted for publication, 206 were rejected, 17 were withdrawn, and 46 were pending as the year ended.

In addition to the regular monthly issues, two *Journal* issues included a special Part 2. The first was the final report of the AAMC's Task Force on Graduate Medical Education titled, *Graduate Medical Education: Proposals*

for the Eighties and the second was *Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management*. Six supplements (carried as part of the regular issues) were produced: "Continuing Education of Health Professionals: Proposals for a Definition of Quality," "External Examinations for the Evaluation of Medical Education Achievement and for Licensure," "Quality of Preparation for the Practice of Medicine in Certain Foreign-Chartered Medical Schools," "AVLINE: A Data Base and Critical Review System of Audiovisual Materials for the Education of Health Professions," "AAMC Annual Meeting and Annual Report, 1981," and "The Maintenance of High Ethical Standards in the Conduct of Research."

About 24,000 copies of the annual *Medical School Admission Requirements*, 4,000 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, were also 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), printed twice a year with a circulation of 1,000; and *Council of Academic Societies Brief*, published quarterly for a circulation of 5,000.

Last year the Association and Jossey-Bass Inc., Publishers agreed to publish important contributions to the medical education literature in an AAMC Series in Academic Medicine. The first two volumes in the series, *Quality Assurance and Cost Containment in Health Care: A Faculty Guide* and *Principles of Quality Assurance and Cost Containment in Health Care: A Guide for Medical Students, Residents, and Other Health Professionals*, have now been published. Four other volumes are in process.

Information Systems

The Association's general purpose computer system continues to grow and the information systems continue to expand. The Association currently has three Hewlett Packard HP-3000 computers supporting over 80 terminals used by the Association staff and a high speed laser printer which can electronically generate forms and emulate the photocomposition of documents as well as print the volumes of reports required to support the Association's information needs. In addition to comprehensive information systems focusing on students, faculty and institutions, the Association has significantly expanded its use of this facility in support of membership services.

The largest volume of information maintained by the Association focuses on individuals engaged in the pursuit of a medical education: applicants to, students in, and graduates of U.S. medical schools. A continuing effort is underway to organize more efficiently the information gathered during the examination-application-matriculation-graduation process and make it more readily available. This system serves as the basis for special reports generated throughout the year and provides answers to questions posed by medical school personnel and Association staff. It is used for regular descriptive studies of medical school applicants and issue-oriented studies.

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

Association personnel responding to inquiries from applicants and medical school personnel.

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

The student records system has information on students enrolled in U.S. medical schools. This system, maintained in cooperation with the medical schools, follows medical students from matriculation through graduation. The information in the student records system is supplemented 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 salaried faculty at U.S. medical schools. This information is maintained in cooperation with medical school staff by Association personnel having online access to update the information. Data in the Faculty Roster system are periodically reported to the medical school in summary fashion, enabling the schools to obtain an organized, systematic profile of their faculty. The faculty salary survey system contains information from the Association's annual survey of medical school faculty salaries. This information is used for the annual report on medical school faculty salaries and is available on a confidential, aggregated basis in response to special inquiries.

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

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

An ancillary system to the Institutional Profile System has been developed to process Part I of the Liaison Committee on Medical Education annual questionnaire. This allows data input and on-line editing of the data, and generates reports that identify errors and inconsistencies in the data on the questionnaires and 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 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 expenses survey for university-owned hospitals, and the executive salary survey. These are the basis of four annual reports generated by the Association and provide answers to special requests made by the

member hospitals.

The use of information systems to provide direct services to constituents has increased greatly during the past year. In addition to the Association's membership system, through which labels are produced for the *Weekly Activities Report* and the *Journal of Medical Education*, a number of information systems have been developed to meet specialized needs of Association constituent groups. Information systems currently support the activities of the Council of Teaching Hospitals, the Group on Business Affairs, the Group on Institutional Planning, the Group on Medical Education, the chief undergraduate health profession advisors, the Council of Academic Societies and the women in medicine activities. These systems are used to produce labels for mailing to the groups, correspondence to selected members, and membership directories. An expansion of the Association's membership services information system to integrate the individual membership systems and incorporate such features as a rapid correspondence (mailgram) or electronic mail facility is currently under investigation.

Data collection and dissemination efforts continue to give attention to special areas of concern to medical education. Among the areas currently receiving attention are the validation of the Medical College Admission Test, the General Professional Education of the Physician project, and minority access to medical education. Association staff will continue to use all available information resources to illuminate these and other areas of importance to medical education.

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AAMC Membership

| Type | 1980-81 | 1981-82 |
|---------------------------|---------|---------|
| Institutional | 123 | 123 |
| Provisional Institutional | 3 | 4 |
| Affiliate | 16 | 16 |
| Graduate Affiliate | 1 | 1 |
| Subscriber | 18 | 16 |
| Academic Societies | 71 | 73 |
| Teaching Hospitals | 410 | 416 |
| Corresponding | 28 | 31 |
| Individual | 1301 | 1300 |
| Distinguished Service | 52 | 51 |
| Emeritus | 50 | 47 |
| Contributing | 4 | 4 |
| Sustaining | 12 | 12 |

Treasurer's Report

The Association's Audit Committee met on August 27, 1982 and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1982. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 9, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled \$11,420,422. Of that amount \$9,775,828 (86%) originated from general fund sources; \$591,711 (5%) from foundation grants; \$1,052,883 (9%) from federal government reimbursement contracts.

Expenses for the year totaled \$9,667,128 of which \$8,142,886 (84%) was chargeable to the continuing activities of the Association; \$470,276 (5%) to foundation grants; \$1,052,883 (11%) to federal cost reimbursement contracts; \$1,083 to Council designated reserves. Investment in fixed assets (net of depreciation) increased \$134,838 to \$1,155,001.

Balances in funds restricted by the grantor increased \$91,628 to \$562,624. After making provisions for reserves in the amount of \$533,358 principally for special legal contingencies, housestaff meetings, investment in building and MCAT and AMCAS development, unrestricted funds available for general purposes increased \$757,344 to \$7,533,316, an amount equal to 78% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintains as a goal an unrestricted reserve of 100% of the Association's total annual budget. It is of continuing importance that an adequate reserve be maintained.

The Association's financial position is strong. As we look to the future, however, and recognize the multitude of complex issues facing medical education, it is apparent that the demands on the Association's resources will continue unabated.

Association of American Medical Colleges
Balance Sheet
June 30, 1982

| | |
|---------------------------------|---------------------|
| ASSETS | |
| Cash | \$ 191,053 |
| Investments | |
| Certificates of Deposit | 12,226,309 |
| Accounts Receivable | 580,907 |
| Deposits and Prepaid Items | 32,606 |
| Equipment (Net of Depreciation) | 1,155,001 |
| Total Assets | \$14,185,876 |

LIABILITIES AND FUND BALANCES

| | |
|--|---------------------|
| Liabilities | |
| Accounts Payable | \$ 862,043 |
| Deferred Income | 1,169,403 |
| Fund Balances | |
| Funds Restricted by Grantor for Special Purposes | 562,624 |
| General Funds | |
| Funds Restricted for Plant Investment | 496,856 |
| Funds Restricted by Executive Council for Special Purposes | 2,406,633 |
| Investment in Fixed Assets | 1,155,001 |
| General Purposes Fund | 11,591,806 |
| Total Liabilities and Fund Balances | \$14,185,876 |

Association of American Medical Colleges

Operating Statement

Fiscal Year Ended June 30, 1982

SOURCE OF FUNDS

| | |
|------------------------------------|---------------------|
| Income | |
| Dues and Service Fees from Members | \$ 2,722,516 |
| Grants Restricted by Grantor | 591,711 |
| Cost Reimbursement Contracts | 1,052,883 |
| Special Services | 4,638,908 |
| Journal of Medical Education | 100,217 |
| Other Publications | 342,767 |
| Sundry (Interest \$1,542,430) | 1,971,420 |
| Reserves | 1,083 |
| Total Source of Funds | \$11,421,505 |

USE OF FUNDS

| | |
|--|---------------------|
| Operating Expenses | |
| Salaries and Wages | \$ 4,266,833 |
| Staff Benefits | 661,535 |
| Supplies and Services | 3,611,082 |
| Provision for Depreciation | 281,630 |
| Travel and Meetings | 788,307 |
| Loss on Disposal of Fixed Assets | 1,454 |
| Interest Expense | 1,465 |
| Provision for Contract Adjustment | 54,822 |
| Total Expenses | 9,667,128 |
| Increase in Investment in Fixed Assets (Net of Depreciation) | 134,838 |
| Transfer to Executive Council Reserved Funds for Special Programs | 533,358 |
| Reserve for Replacement of Equipment | 237,209 |
| Increase in Restricted Fund Balances | 91,628 |
| Increase in General Purposes Funds | 757,344 |
| Total Use of Funds | \$11,421,505 |

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