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annual report

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John A. D. Cooper

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Council of Teaching Hospitals

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Organization of Student Representatives

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Ronald W. Estabrook

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Emanuel M. Papper

Chairman, Council of Teaching Hospitals

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Robert A. Derzon

1973-74 ANNUAL REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

CONTENTS

President's Message	3
The Councils	4
National Policy.....	8
Working with Other Organizations.....	10
Education	12
Biomedical Research	14
Health Care	16
Faculty	17
Students.....	18
Institutional Development	20
Teaching Hospitals	22
Communications	23
Information Systems.....	24
Treasurer's Report	25
AAMC Membership.....	27
AAMC Committees	28
AAMC Staff	34

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Madison B. Brown

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President's Message

We are entering a new era of governmental direction and control over the health sector.

A number of factors have contributed to this rising tide of domination which threatens to engulf the entire enterprise. There is a growing concern about the rising costs of health care which are outstripping the spiralling inflation that has gripped every sector of the economy. This concern is heightened by the increasing share of health care costs being borne by government at all levels. There is dissatisfaction with the progress being made in providing accessibility to medical care in underserved urban and rural areas and with the growing difficulty of obtaining care by those previously well-served. The disillusionment of the nation with Watergate and related affairs has also played a role. Those holding office are seeking ways to regain favor with what many of them perceive to be a disenchanted electorate. Expressions of dissatisfaction with the health care establishment, especially the medical schools, provide one way to accomplish this task.

New legislation abounds with proposals to mandate more government intervention in all aspects of the health care sector. Federal support for biomedical research, health care for the poor and elderly, and the training of health professionals carries new and often unrelated requirements as conditions for award. The medical schools and their teaching hospitals, which have become increasingly dependent on Federal funds as their other fiscal resources become less adequate to carry out their socially vital missions, are being used as a convenient handle to advance the federal government's solutions to perceived shortcomings in the national health scene.

This is very apparent in the renewal of the Comprehensive Health Manpower Training Act of 1971. This was originally conceived as a program to provide a Federal share of the costs of educating physicians and other professionals to assure an adequate supply of human capital to carry out federally-mandated programs in health. It is now viewed as a vehicle to remedy geographic distribution, to further increase the rate of production of physicians, to change the mix of specialists, to define the departmental organization, the curriculum and the financing for family medicine programs, and to determine the allocation of resources to medical school outreach programs.

It is clear that the original objectives of the manpower legislation have been lost in the rush to effect simple and hasty solutions to complex problems. Providing some fiscal stability to the medical schools through unencumbered capitation may have come to a rapid end. The costs of implementing the requirements for support may exceed substantially the funds received under the Act.

The Social Security Amendments of 1972 imposed further constraints on the academic medical center. New restrictions on the reimbursement of physicians for medical care rendered in the teaching setting have been delayed pending the completion of a study by the Institute of Medicine. This study will also encompass geographic and specialty distribution and the education and training of foreign medical graduates. Regulations on reimbursement for hospital costs growing out of the amendments have created serious financial problems for teaching hospitals. The criteria used for setting the limits and charges did not take into account the unique features of the large teaching hospitals which provide most of the complex tertiary care in the American system. Efforts to contain inflationary pressures may lead to further actions to make health care delivery a fully federally-controlled industry.

Preserving the quality and integrity of the education, research, and service programs of the academic medical centers in the face of these forces constitutes the most important challenge confronting us in the years ahead. This annual report chronicles the broad range of activities through which the Association, working with its members, is attempting to meet these challenges.

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

The Councils

EXECUTIVE COUNCIL

The Executive Council held four meetings during the year. Deliberations at these meetings covered a wide range of matters affecting the medical schools and teaching hospitals. The Council acted on a number of issues arising from discussions of the constituent Councils or referred for action by the membership. Except in cases where immediate action was needed, all policy matters were referred to the constituent Councils for discussion and recommendation before final action was taken.

This year marked the appointment of the first Vice President of the AAMC. At its March meeting the Executive Council appointed John F. Sherman to this position. Dr. Sherman's responsibilities also include serving as Director of the Department of Planning and Policy Development. Dr. Sherman's previous position was as Deputy Director of the National Institutes of Health, where he had served for twenty-one years.

The Annual Retreat of the elected officers was held in December prior to the first meeting of the new Executive Council. Five major areas of activity were identified by the Retreat participants and reaffirmed by the Executive Council as major priorities for the Association during the coming year. These were the completion of a report on the financing of medical education, the development of a specific Association position on national health insurance, further consideration of solutions to the specialty and geographic distribution of physicians, the coordination of agencies collecting data in the health field, and an examination of the role of the medical schools and teaching hospitals in educating the public about health.

The Executive Council approved two reports of the Sprague Committee on the Financing of Medical Education. The first report set forth the Association position on the costs attributable to undergraduate medical education, based on samples taken at twelve representative institutions. The second report outlined the Association's views on the responsibility for financing medical education, including the roles of both the private and public sectors.

Another Retreat priority was pursued through the establishment of a National Health Insurance Task Force chaired by Dr. James F. Kelly. After several meetings at which all of the pending legislative proposals and varying philosophies were discussed extensively, the NHI Task Force developed a position which supported no particular bill, but set forth recommendations which the Association would support in any pending legislation. The Task Force report was approved by the Executive Council to form the basis for any future Association testimony in this area.

As one of the parent organizations of the Coordinating Council on Medical Education, the AAMC is asked to ratify all policy statements issued by that body. The Executive Council this year approved the first two policy statements to be forwarded by the Coordinating Council. The first, entitled "Statement on the Responsibilities of Institutions, Organizations and Agencies Offering Graduate Medical Education," was similar to a policy established by the Assembly several years ago. The second policy statement, entitled "Physician Manpower and Distribution: The Primary Care Physician," was developed by a CCME committee seeking to make recommendations toward alleviation of the problems of specialty distribution of physicians.

The Executive Council met with the Association's attorneys on several occasions last year to discuss the possibility of taking legal action against the Administration to seek the release of funds impounded for research, research training and health manpower special projects. After considerable deliberation, the Executive Council authorized the AAMC lawyers to initiate legal action. After both the District Court and the U.S. Court of Appeals ruled in favor of the Association, the Administration released the funds which had been impounded for these purposes. No significant portion of fiscal year 1975 funds was impounded, largely as a result of these actions.

The AAMC Task Force on Foreign Medical Graduates issued its report earlier this year. After considerable discussion and the adoption of an amendment suggested by the Council of Deans, the Executive Council approved this landmark report, which puts the Association on record as

favoring a uniform qualifying examination at the interface of undergraduate and graduate medical education. The thrust of the report is to subject both U.S. graduates and foreign graduates to the same process of evaluation and to deter the immigration of foreign-trained physicians who cannot meet this minimum qualifying standard.

The Association has continued to work closely with the Department of Health, Education and Welfare and the Social Security Administration over the issuance of regulations implementing sections of the 1972 Social Security Amendments. Regulations which would have altered the pattern of reimbursement among teaching physicians were deferred by Congressional action pending a study to be undertaken by the Institute of Medicine. Regulations setting ceilings on hospital costs have been implemented for a period of one year despite the objections of the AAMC. The Association staff has been working closely with DHEW officials to attempt to obtain more equitable regulations at the end of the one-year period.

The Executive Council approved a policy statement on moonlighting by house officers which states that moonlighting is inconsistent with the educational objectives of house officer training. The statement continues to say that moonlighting should be an institutional consideration and establishes guidelines which institutions might wish to consider in cases where moonlighting is permitted.

The Executive Council approved the report of its Review Committee on the Medical College Admissions Assessment Program. This report sets forth priorities for the revision of the Medical College Admission Test and for future expansion of the MCAT into noncognitive areas. The Executive Council recommended that these activities be financed by an increase in the MCAT fee.

Several changes in the AAMC Bylaws were recommended by the Executive Council and approved by the Assembly. The first increased the Assembly representation of the Council of Academic Societies and the Council of Teaching Hospitals, each to equal one-half of the number of representatives of the Council of Deans. A second change established a category of Distinguished Service Membership in the Association. Individuals elected to this category of membership will be those who have previously been active in the Association but because of their current positions are no longer members of any AAMC Council. A third change expanded the membership of the Executive Council to include one Distinguished Service Member and one ad-

ditional representative of the Council of Teaching Hospitals.

The Council's Executive Committee met prior to each Executive Council meeting and by conference call on numerous occasions throughout the year. The Executive Committee was particularly vigilant in monitoring the constant changes in health manpower legislative proposals. Between meetings of the Executive Council, the Executive Committee was called upon to adapt the Association's position to the evolving legislation. The Committee also held informal discussions during the year with an array of DHEW officials including Under Secretary Frank Carlucci, Assistant Secretary for Health Charles Edwards, Deputy Assistant Secretary for Health Theodore Cooper, NIH Director Robert Stone, and HRA Administrator Kenneth Endicott.

The Executive Council along with the AAMC Secretary-Treasurer, Finance Committee and Audit Committee maintained careful surveillance over the fiscal affairs of the Association and approved a moderately expanded general funds budget for fiscal year 1975.

COUNCIL OF DEANS

The Council of Deans held two national and several regional meetings during the year. The Administrative Board of the Council met four times in the interim between the national meetings and acted on behalf of the Council on all issues presented for the consideration of the Executive Council.

At its 1973 business meeting, the Council endorsed a proposed policy of the Liaison Committee on Medical Education that medical education programs which do not culminate in the award of the M.D. degree will be considered for accreditation only if the program is an existing accredited or provisionally accredited two-year program, a new basic science program in an institution committed to establishing a full M.D. degree program with their own resources or as part of a consortium, or a new basic science program in an institution formally affiliated with one or more established medical schools. In this last case, the program would be accredited as a component of the M.D. degree-granting institution or institutions.

In addition to recommending that new institutional and affiliate institutional members be elected by the Assembly, the Council endorsed a proposal which would provide the Council of Academic Societies and the Council of Teaching Hospitals with greater representation in the

THE COUNCILS

Assembly. The Council endorsed the establishment of a new class of members, "Distinguished Service Members," which would provide a means for recognizing the active and meritorious participation in the affairs of the AAMC of persons no longer members of any Council. Such members would have honorary membership on the Council recommending his/her election and would be invited to all meetings of the Council and have the privilege of the floor without vote. These members as a group would be provided a seat on the AAMC Executive Council. The Council heard reports of the Management Advancement Program, the Coordinating Council on Medical Education, and a program of the National Fund for Medical Education.

A second activity of the Council at the annual meeting was a joint meeting with the Administrator of Veterans Affairs, the VA Chief Medical Director, members of his staff, and administrators of VA hospitals. The Council also co-sponsored with the Group on Medical Education and the Group on Student Affairs a program on evaluation. This meeting consisted of two half-day sessions which focused on a consideration of the Association's Medical College Admissions Assessment Program and the Report of the Committee on Goals and Priorities of the National Board of Medical Examiners.

The Council's spring meeting continued the recently established tradition of a two and one-half day retreat devoted to a consideration of a series of problems of concern to deans under a common theme. The theme of this year's meeting was entitled "Zero Institutional Growth: Implications for Vitality and Leadership." The purpose of the meeting was to identify the capacity for institutional renewal in a period of constrained resources. The Council heard a series of thoughtful presentations on such matters as planning and governance, space management, tenure, collective bargaining, hospital regulation, and affirmative action requirements.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies, at its Annual Meeting, sponsored a half-day program on "Certain Ethical Aspects of Biomedical Research." This topic was extremely timely; during the ensuing months national concerns about protecting the rights of human subjects resulted in revised DHEW regulations and the passage of legislation establishing a national commission to study the problems relating to research on human subjects. Council of Academic Societies members were

heavily involved in the national debate on this issue.

At its spring meeting, the Council sponsored a debate on the issues of tenure and collective bargaining by faculties in institutions of higher education. Reduced resources and a slowing growth of colleges and universities have made these subjects a major national concern.

The Council modified its rules and regulations to provide for the election of a seven-member Nominating Committee, chosen from those representatives present at the Annual Meeting, and providing for the Chairman of the Administrative Board to be the non-voting Chairman of the Nominating Committee. The Administrative Board was increased from nine to twelve members. Under the new rules three members are the Chairman, Chairman-Elect and immediate Past-Chairman; nine other members are elected for three-year terms with an equal balance being provided between basic and clinical science representatives.

The new dues structure for the Council, which provides for a sliding dues scale related to the active membership of each member society, was approved by the Assembly at the Annual Meeting and became effective for the fiscal year beginning July 1, 1974. Eleven new societies were elected to membership in the Council, while three resigned.

By action of the Assembly, the CAS voting membership in the Assembly was increased from 35 to 57 votes. The number of votes in the Assembly will, in the future, be adjusted so as to be equal to one-half of the number of institutional members. The CAS Administrative Board remained active throughout the year, reviewing all items which eventually were acted upon by the Executive Council.

COUNCIL OF TEACHING HOSPITALS

The COTH Administrative Board held four meetings during the year, developing the programs and interests of teaching hospitals and providing input to all policy considerations of the Executive Council.

Federal governmental controls on the hospital industry and their specific impact on teaching institutions continued to be an area of particular interest to the Council. AAMC position statements were developed regarding the implementation of numerous sections of the 1972 Amendments to the Social Security Act (P.L. 92-603) including: Section 227, "The Payment of Teaching Physicians;" Section 223, "Cost Limitations in Hospitals;" Section 208, "Utilization Review;" and Section 221,

"Limitation on Federal Participation in Capital Expenditures by Hospitals." The COTH Ad Hoc Committee on Economic Controls monitored governmental policies regarding inflation as they pertain to the health industry and made suggestions on redeveloping Section 223 cost control regulations.

Special committees of the Council have assisted the Joint Commission on the Accreditation of Hospitals (JCAH) in reviewing current standards with regard to the particular circumstances and problems of teaching institutions. A similar project is underway with respect to revision of JCAH model medical staff bylaws. The Council continues to provide financial and logistic support to researchers interested in studying the financing, organization and provision of health services in the academic medical center environment. Last year two COTH Research Awards of \$2,500 each were granted doctoral students pursuing topics of interest to the Council.

COTH spring regional meetings were held in Salt Lake City, Atlanta, Chicago, and New York City. At the Western regional meeting Dr. Stuart Altman, Deputy Assistant Secretary of DHEW, discussed the Administration's national health insurance proposal and Phase IV health industry controls. Walter J. McNerney, President of the Blue Cross Association made a presentation entitled "Special Problems of Teaching Hospitals." At the Southern regional meeting a session was devoted to addressing patient care studies, utilization review, and Professional Standards Review Organizations. Daniel W. Zwick, Associate Administrator of the Health Resources Administration, discussed "The Health Resources Administration: Current Programs, Organization, Financing and Priorities." The Midwest-Great Plains regional meeting addressed "The Role of the Organized Medical Staff in Academic Medical Centers and Institutional Responsibility for Graduate Medical Education." The Northeastern regional meeting was devoted to discussing case mix adjustment under Phase IV Economic Stabilization Program regulations.

ORGANIZATION OF STUDENT REPRESENTATIVES

The Organization of Student Representatives has continued to evolve as an effective vehicle for

medical student contribution to the Association's program and policy development process.

At the OSR Annual Meeting in 1973, task force groups addressed such issues as the admissions crisis, legislation and medicine, financial aid, student records, and OSR structure and function. Also at the Annual Meeting, the Assembly approved two OSR-sponsored resolutions which urged the AAMC to provide more specific information on admissions requirements to applicants and premedical advisors.

The Executive Council approved a resolution in March providing for the OSR Administrative Board to meet four times per year in conjunction with the meetings of the other administrative boards of the Association. The coordination of OSR Administrative Board meetings with those of the other Councils provides a means for more effective participation in Association activity. The Administrative Board met in January, March, and June to conduct OSR business, and a fourth board meeting was held in September to consider resolutions and plan for the Annual Meeting.

During the spring, the OSR sponsored regional meetings which were held in conjunction with the Group on Student Affairs (GSA) regional meetings. At these meetings, OSR members participated in joint sessions with the GSA; held discussion sessions on a wide variety of issues including the NBME Goals and Priorities Report, financial aid, and NIRMP; and conducted regional business meetings.

The OSR has been instrumental during the past year in developing a procedure for dealing with violations of the NIRMP rules. NIRMP Monitoring Committees have been established on medical school campuses at the recommendation of both OSR and GSA as a means by which violations to NIRMP procedures can be reported to appropriate national authorities. Another project in which the OSR has been actively involved is the review of the National Board of Medical Examiners Goals and Priorities Report. Position papers were submitted by the four OSR regional groups to the AAMC GAP Task Force for consideration in formulating an AAMC policy statement on the report.

National Policy

During the past year, the Association was unusually active in the consideration of national policies affecting the medical schools and teaching hospitals. Several major health initiatives which had been pending for nearly a year were finally taken up by the Administration and the Congress. At the forefront of national debate on health issues were the questions of health appropriations, the fate of research training programs sponsored by the National Institutes of Health, the extension of Federal participation in health professions education, and the design of a system of national health insurance. The Association responded to these and a variety of other policy issues through testimony, discussions with key policy makers, commentary on proposed regulations, issuance of analyses and reports and, in some critical instances, through the initiation of lawsuits.

The fiscal year 1974 appropriations bill, approved by the Congress, contained an unusual provision to allow the President to impound up to five percent of the Labor-HEW funds appropriated for any given program. In return for this grant of authority the President signed the measure, thus avoiding the problems created by his veto of the 1973 appropriations bill. The President complied with the wishes of the Congress and allocated all 1974 funds not within the five percent margin of discretion.

In January 1974, the Administration released its proposed budget for fiscal 1975. Although the document was generally conciliatory, it attempted to make further cutbacks in Federal funds for biomedical research, research training, and health manpower programs. The Association scrutinized the budget request and pointed out its deficiencies in testimony before the House and Senate Appropriations committees. The Association worked closely with the Coalition for Health Funding to advise the Congress of the special activities and unique needs of federally-funded health programs.

The Association also monitored Congressional Administration activities which would affect national policies on biomedical research. During Congressional hearings, the Association emphasized the importance of continued programs of research, research training, and general research

support, as well as the need for additional staff positions at the NIH. It also warned the Congress of the dangers of placing too much emphasis on targeted, rather than basic, research.

As part of its continued effort to assure the quality and integrity of federally-sponsored biomedical and behavioral research, the Association filed an *amicus curiae* brief on behalf of the DHEW in a suit brought by the Washington Research Project to obtain grant applications and evaluation documents from the National Institute of Mental Health. The Association advised the Federal appellate court that the release of this information would threaten the integrity of the scientific peer review system, violate the proprietary interest of creative research investigators, and undermine the quality of government-sponsored research.

The policy statement of the AAMC Committee on the Financing of Medical Education was approved by the Executive Council and distributed to the Administration and the Congress. This statement—calling for multiple sources of support to ensure diversity in medical education, adequate funding for research, and equal educational opportunities for all students—formed the basis of the Association's position on the appropriate role of the Federal Government in the education of health professionals. An *ad hoc* Committee on Health Manpower had previously developed specific AAMC recommendations for the extension of the Comprehensive Health Manpower Training Act, which expired June 30, 1974.

During Congressional hearings on the extension of the health manpower legislation, the Association drew upon the findings and recommendations of these two committees, as well as those of the Institute of Medicine of the National Academy of Sciences. The Association worked closely with the Federation of Associations of Schools of the Health Professions in developing its recommendations. It urged that a national policy be adopted which would allow stable, continuing institutional support on a capitation basis, with special project assistance for national emphasis programs. The Association also supported financial assistance to students to help lower economic barriers, greatly increased funding for the over-

subscribed National Health Service Corps, and assistance for capital expenses. The AAMC vigorously opposed attempts to require mandatory service obligations for all medical students as well as Federal intrusion into the areas of curriculum design and licensure.

Meanwhile, the Association continued to consider other aspects of medical education. It met with the Educational Council on Foreign Medical Graduates and the Commission on Foreign Medical Graduates to discuss the growing problems resulting from the immigration of graduates of foreign schools with inadequate medical educational programs. The organizations recommended establishing a national policy requiring FMGs to pass a uniform qualifying examination, and eliminating dual standards of admission. The Association's *ad hoc* Task Force on FMGs further recommended that the nation recognize that U.S. medical schools should be the major resource for U.S. physicians.

The Association supported a national policy of rectifying past educational discrimination through the use of affirmative action programs to provide adequate minority representation in higher education. The AAMC filed an *amicus curiae* brief in the U.S. Supreme Court, supporting the legality of the affirmative action program of the University of Washington School of Law. The high court later held moot the case (*DeFunis v. Odegaard*) involving a charge of "reverse discrimination" against a white male student.

The Association continued to play an active role in the development of national policies for health care and patient service. Foremost among the national health care issues was the debate on national health insurance legislation. The Association's Task Force on National Health Insurance investigated the deficiencies in the present health delivery system, the distortions caused by financing mechanisms, and the role of national health insurance in modifying the delivery system. Based on the Task Force's findings, the AAMC

joined the national debate and advocated the integration of all Federal health care programs into a single national health insurance system. Included among the Association's recommendations to the Congress were compulsory universal coverage and a comprehensive benefit structure. The Association supported state regulation of providers, with Federal guidelines and standards for efficient and fair provider reimbursement. The continued financing of graduate medical education through funds for inpatient and ambulatory care was singled out as a necessary and appropriate Federal role.

Additional legislative issues concerned the extension of the Hill-Burton program and the establishment of health planning systems. During Congressional hearings, the Association urged the creation of a Presidential-level Council of Health Advisors and a system of health planning based at the area level, with state-level regulation, and Federal developmental aid.

The Association continued to respond to regulations proposed by DHEW to implement specific provisions of the 1972 Social Security Amendments. Regulations limiting the reimbursement of physicians providing care in the teaching setting were delayed by legislative action, pending completion of an Institute of Medicine study. Regulations imposing a ceiling on hospital charges went into effect for a one-year period despite the objections of the AAMC. The Association staff is monitoring the activities of DHEW to ensure that regulations published after the one-year period will be more equitable and less arbitrary.

In response to the growing public concerns over inflation in the health sector, the AAMC worked closely with the Cost of Living Council on the development of Phase IV guidelines on medical care costs. Since the expiration of the COLC in April 1974, the Association has been invited to participate in President Ford's summit meetings on inflation.

Working with other Organizations

As one of the five parent organizations of the Coordinating Council on Medical Education, the AAMC has been active in the many areas which the CCME is beginning to explore. During the 1973-74 year, the CCME acted on the recommendations of nine of its committees and forwarded major actions to the parent organizations for discussion and ratification.

The major thrust of the CCME during this past year was in the area of health manpower and physician distribution. Its ad hoc Committee on Physician Distribution prepared a paper entitled, "Physician Manpower and Distribution: The Primary Care Physician." This paper has been sent to the parent organizations for reaction and response. The Committee has been expanded and asked to address itself to the impact of foreign medical graduates on medical education and the delivery of health care. This report and other actions of the CCME will be brought to the parent organizations in the coming months.

The Liaison Committee on Medical Education continues to serve as the nationally recognized accrediting agency for programs of undergraduate medical education. During the 1973-74 academic year 37 accreditation surveys were conducted by the LCME as well as numerous consultation visits to universities contemplating the development of a new medical school. The attention of the LCME and its Task Force on Accreditation focused on the review of medical school applications submitted to the Veterans Administration for financial support under PL 92-541. Under Subchapter I of the law—Pilot Program for Assistance in the Establishment of New State Medical Schools—the LCME reviewed five applications and issued one letter of reasonable assurance. Under Subchapter II—Grants to Affiliated Medical Schools—the LCME reviewed 24 medical school applications and issued letters of reasonable assurance to 16 schools.

The Liaison Committee on Graduate Medical Education has continued to meet regularly and is awaiting ratification of its bylaws by the five parent organizations so that it may move ahead with its function of accrediting programs in graduate medical education in conjunction with the Residency Review Committees. This year, the

LCGME agreed to seat a representative of the national housestaff organizations. The LCGME has devoted considerable time to reviewing the actions of the Residency Review Committees. The LCGME has reaffirmed that its relationship to the Residency Review Committees is purely to help to develop standards, review guidelines and promote studies for the improvement of graduate medical education programs, maintenance of their quality, and responsiveness to the needs of the public. In addition, the LCGME has devised an appeals mechanism for programs whose approval has been withheld or withdrawn.

The Coordinating Council on Medical Education has approved a proposal to establish a Liaison Committee on Continuing Medical Education. When all five parent organizations approve the formation of the LCCME, it will begin to function parallel to the other liaison committees.

The Association has participated in a series of deliberations with 15 professional organizations relating to a proposed National Commission on Certification of Physician Assistants. The participants have agreed that it would serve the best interest of the public and other health professionals, as well as the physician's assistants themselves, if a free-standing commission were established to certify physician's assistants. The purpose of the Commission would be to safeguard the public and potential employers by maintaining high professional and ethical standards in the profession of physician's assistants through recognition of those achieving and maintaining appropriate knowledge and skill in the field.

The AAMC continues to work closely with the American Medical Association and the American Hospital Association on issues of common interest. Major collaborative efforts were undertaken this year in the areas of health manpower legislation and on regulations proposed by the Social Security Administration to limit hospital per diem rates. In addition, the AAMC Executive Committee has met with the officers of each of these important national organizations to discuss other issues and to facilitate cooperation in the future.

The Association has maintained its close working relationship with the staff of the Institute of Medicine of the National Academy of Sciences.

The IOM this year completed and published its study on the costs and financing of medical education. The Association took a position generally supportive of the IOM effort and issued a detailed analysis of the differences between the IOM study and that of the AAMC Committee on the Financing of Medical Education. The Association has been actively involved in a second IOM study which will examine graduate medical education and the reimbursement of physicians in the teaching setting.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with members representing both the educational and professional associations of eleven different health professions. Much of the Federation's efforts during the past year were devoted toward the upcoming renewal of health manpower legislation. A Federation position on the renewal of the manpower authority was developed and each member association agreed to support this proposal as a minimum. The Association staff has also worked closely with the staff of the American Association of Dental Schools on such matters as health manpower legislation, development of data bases, and the sharing of information on matters of mutual concern.

Liaison with associations representing higher education outside the health field was also strengthened during the year. Discussions on various issues of common interest were held with representatives of the American Council on Education, the Association of American Universities and the National Association of State Universities and Land-Grant Colleges. Of particular usefulness was the informal arrangement whereby different organizations took the lead in various legal matters. For example, in a court case involving government patent policies, the ACE developed a draft of an *amicus curiae* brief which the AAMC later joined. In another instance, the AAMC accepted primary responsibility for developing a position opposing unreasonably restrictive regulations proposed by DHEW on conflicts of interest involving former DHEW employees. The exchanges with these same organizations have led to an informal arrangement whereby each has accepted the responsibility for monitoring policies developed by specified Federal agencies in areas of common interest.

The Coalition for Health Funding, which the Association helped form five years ago, continues to grow in size, now having 42 non-profit health related associations in its membership. A Coalition

document analyzing the Administration's proposed health budget for fiscal year 1975 and making recommendations for increased funding is widely used by Congress and the press.

The AAMC continues to work with the Association for Academic Health Centers on issues of concern to the vice presidents for health affairs. Representatives of each organization are invited to the Executive Council and Board meetings of the other. In addition, these governing bodies of the two organizations approved guidelines formalizing ways in which the two associations would work together in the future.

The Association has continued to help strengthen medical education in the Americas by participating in the Panamerican Federation of Associations of Medical Schools. Specific projects this year involved four key areas: 1) exploring the mutual benefits to be derived by social security institutions and medical schools in Latin American countries; 2) improving the managerial capability in Latin American medical schools; 3) expanding the use of self-instructional materials throughout North and South America, and 4) developing the role of medical education in community health programs.

With assistance from the W. K. Kellogg Foundation, the PAFAMS chief for programs of research and planning in medical education spent a month at AAMC headquarters this year to plan for a network by which teaching and learning materials might be produced and shared throughout the Americas. The Josiah Macy, Jr. Foundation agreed to provide AAMC with professional staff support for the next two years to develop and carry out joint AAMC-PAFAMS activities in this area.

Funds from the U.S. Agency for International Development are supporting a study in four developing countries of health professions schools and the extent to which they and their faculties are involved in the planning of integrated systems for primary care and health maintenance. A grant from the Commonwealth Fund continues to assist with AAMC's comparative study of medical education and health services as they relate to one another in three developed countries presently operating national health insurance plans.

This year AAMC again contributed administrative and logistic support to the World Federation for Medical Education, helping to organize the International Conference on the Physician and Population Change held in Stockholm. The Association is represented in WFME through the Panamerican Federation of Associations of Medical Schools.

Education

The Association continued to expand its concerns across the continuum of medical education. The medical schools are increasingly becoming engaged with their broad responsibilities for graduate medical education. At least sixty schools reported in a survey that they are moving toward assuming institutional responsibility for graduate medical education. With the increasing national concern being expressed about modifying the distribution of graduate education opportunities and making the number of graduate positions more closely fit the number of U.S. students seeking graduate medical education, this movement by the academic medical centers is particularly important. Whether the private sector can effectively control the size and characteristics of the graduate medical education universe is being carefully evaluated by the Congress. Two bills establishing a Federal role in controlling graduate medical education were introduced in 1974. The fate of such legislation will, in large measure, depend upon the private sector's ability to change specialty distribution without Federal initiative.

Closely tied to the Association's concerns for graduate medical education was the report of the Task Force on Foreign Medical Graduates, which was approved by the Executive Council in June. The Report recommends that the Association endeavor to have all students seeking graduate medical education (whether U.S. or foreign educated) demonstrate equivalent levels of competence by passing a national qualifying exam. The report further recommends that special programs be developed to study the remedial educational needs of students educated abroad. Support is being sought to implement these special studies.

The concept of a national qualifying examination for all students entering graduate medical education programs in this country is related to the response of the medical education community to the report of the Goals and Priorities Committee of the National Board of Medical Examiners. This report, among other things, recommends to the NBME that a single qualifying examination at the interface between undergraduate and graduate medical education replace the present Parts I, II and III of the NBME certifying examination. A committee drawn from

the Group on Medical Education held regional meetings with representatives from the schools to discuss the implications of the "GAP" report. These discussions stimulated sufficient concern that the Executive Council appointed a special task force for the purpose of developing an Association position on the GAP report. The report of this task force, to be discussed by the Councils at the 1974 Annual Meeting, will be acted upon by the Executive Council after receiving these inputs.

The Medical College Admissions Assessment Program, which was conceptualized through the participation of numerous individuals in regional and national task forces last year, was reviewed by a committee appointed by the Executive Council. The review committee recommended implementation of the program and provided guidance regarding the priorities to be emphasized. Highest priority was given to the development of new separate tests of cognitive assessment to replace the present Medical College Admission Test. The new tests will include reading comprehension, quantitative reasoning, biology, chemistry and physics. High priority was also given to the development of ongoing information and educational services to support the new assessment system. The committee urged that the Association seek outside support to design assessment instruments to evaluate problem-solving and communications skills and other noncognitive characteristics of applicants, including biographical characteristics. The committee emphasized that research efforts should be directed toward the development of better measures of clinical performance and the identification of any personal characteristics which might predict optimal performance. After approving the recommendations of the MCAAP Review Committee, the Executive Council appointed a Committee on Admissions Assessment to work with the staff in implementing the recommendations.

A major grant proposal to continue the Longitudinal Study of 2,200 physicians who graduated in 1960 was submitted to the Bureau of Health Services Research. It is proposed that several strategies be utilized to assess the clinical performance of these physicians, now fifteen years

out of medical school, in an attempt to correlate career outcomes with personal characteristics of these individuals and their schools, as measured during the period from 1956 to 1960. In June a colloquium on career development brought together experts in this field and individuals from the medical schools particularly concerned with the influence of selection and education on ultimate career choice.

The Association's project with the National Library of Medicine and the American Association of Dental Schools to identify, review and access effective non-print educational materials completed its first full operational year. A total of 20,814 separate titles were identified and 1,543 of these were reviewed by nine panels. The review panels considered 805 titles of sufficient educational value and quality to be included in a data base of the National Library of Medicine; of these, 150 were rated as excellent. It is anticipated that by early 1975 these titles, as well as additions provided by further reviews, with abstract descriptions, will be available through a national computer network designated AVLINE which will be similar to the current MEDLINE system for printed material.

With the identification and review system for multimedia materials fully operational, the Association is proceeding with a similar effort in the area of computer-based educational materials. This effort, supported by the National Library of Medicine, will also initiate the development of a

Library of Evaluation Materials, which eventually will provide access to instruments which can be used by the faculties in evaluating educational programs and students.

The Association has completed a feasibility study on developing a health sciences multimedia learning advancement program. This study, supported by the Kaiser Family Foundation and The Commonwealth Fund, is directed toward ultimately improving quality control and evaluation methods for the development and utilization of multimedia learning systems.

The third edition of the *Curriculum Directory* was published this year. This edition provides expanded information on the required and elective programs in all U.S. and Canadian medical schools. Partial support for the publication of this education was provided by the Josiah Macy, Jr. Foundation.

Five issues of *AAMC Education News* have been published. This newsletter, supported by the National Fund for Medical Education, was sent to over 34,000 full-time faculty members listed in the Faculty Roster. More than twenty reports on educational innovations and issues were included in the first volume. A year-end evaluation of the impact of this publication indicated that it is being widely read and is fulfilling a previously unmet need by informing the medical school faculty members about innovative educational programs throughout the country.

Biomedical Research

The AAMC has been actively involved in many aspects of biomedical research policy. The Association was instrumental in procuring the release by President Nixon of over \$165 million in impounded fiscal year 1973 funds. The President's action followed two Federal court rulings in favor of the Association. In ruling for the AAMC, the court held that DHEW Secretary Weinberger and Office of Management and Budget Director Ash had acted unlawfully in refusing to obligate Congressionally-appropriated health manpower and research funds. The court ordered the defendants to release and obligate \$29 million in health manpower special project funds, and \$136 million in NIH funds for research, research training, and fellowships. The Association's suits were among 57 different impoundment actions filed against the Administration in 1973. As a direct result of this lawsuit and the favorable court decisions which resulted, the Administration released and obligated all impounded funds and reestablished research training programs which had been terminated in January 1973.

Prior to this legal action, elimination of the NIH and NIMH research training programs for developing young biomedical investigators had so clearly become the policy of the Federal Government that a meeting of representatives from the major universities responsible for biomedical research training was scheduled. This invitational conference was held in Seattle, Washington for representatives from medical schools, voluntary health agencies, private foundations, the Department of Health, Education and Welfare, and the National Academy of Sciences. The Association and the University of Washington School of Medicine sponsored the session, which focused on developing ideas and plans for the assumption of increased responsibility by nongovernment agencies for planning and monitoring the development of the nation's biomedical research manpower. Three major groups were considered by the conference participants as inseparably interdependent in carrying forward research manpower development: the faculty of the nation's colleges and universities; the informed public, particularly those active in the voluntary health agencies; and legislative and administrative

branches of the Federal Government. Major supporting roles were anticipated from private foundations and commerce.

Rising national concern about the ethical aspects of biomedical research programs was evidenced by the enactment of legislation to establish a national commission for the protection of human subjects of biomedical and behavioral research. In addition, regulations were published to codify the DHEW guidelines for the protection of human subjects. The Association testified in support of the legislation establishing the ethics commission, but indicated that regulatory authority should remain the responsibility of the DHEW Secretary. Association staff participated as consultants to the DHEW committee which drafted regulations on the conduct of biomedical research on individuals with limited ability to give informed consent. In its activities related to the ethical aspects of biomedical research, the Association took a leadership role in encouraging both the institutions and the Council of Academic Societies to respond to the proposed regulations.

In discussions with key Administration and Congressional representatives, the AAMC lent strong support to the system of peer review of proposals for Federal research support. Under attack from within the Administration, the peer review system allows eminent scientists in a particular field to judge which research areas and proposals are most worthy of support. This scientific review reduces the potential influence of politics on the selection of those areas of research activity which have the highest potential for yielding new information.

In testimony before both the House and Senate Appropriations Committees, the Association stressed the importance of the general research support program of the National Institutes of Health in the achievement of the goals of our national biomedical research program. During the past year, the concept of flexible research support demonstrated by the general research support program has been the subject of considerable discussion by DHEW. As part of this review process, the Association was asked to comment on proposed changes in the program, including a merger of the general research support grants and the biomedical sciences support grants. In commen-

ting on the proposed program, the Association stressed that the primary purpose of the general research support program should be to assist those institutions significantly involved in biomedical research in the conduct of these programs. The Association strongly endorsed a continuation of the program's administrative flexibility and also called to the attention of the NIH Division of Research Resources the problem of creating a research base in newly established medical schools. It was suggested that the NIH develop a new and separately identified type of award with its own criteria and a designated sum of money to achieve the highly desirable purpose of broadening the base of institutions significantly involved in the national biomedical research effort.

In conjunction with the staff of the NIH Division of Research Resources, the Association developed a cost analysis and rate setting manual for animal research facilities. This manual will allow these facilities to enhance the quality of animal care and to become more self-supporting through an increased recovery of cost from the facilities' users. Throughout the year the Association participated in discussions with officials of the National Institutes of Health, the Department of Agriculture and other agencies of the Federal government to emphasize that regulations directed toward improving the quality of animal care facilities must not adversely affect the conduct of biomedical research utilizing laboratory animals.

On several different occasions throughout the year, the Association was requested to support legislation directed either at the establishment of new institutes at the National Institutes of Health or directed toward the establishment of a new program to conquer a particular disease. In

response to these requests, the Executive Council approved a policy statement on new research institutes and targeted research programs which reaffirmed the Association's strong belief that a key element in the past and future success of our national effort to conquer disease is a strong, diverse, balanced program of high quality biomedical research. The Executive Council opposed as a matter of considered principle the establishment of additional categorical disease institutes or institutes dedicated to one or more organ systems at the NIH.

However, it was recognized that to accomplish new objectives, it may be necessary to add new responsibilities to the existing programs of the various NIH institutes. The Executive Council, therefore, advised that legislative proposals mandating the establishment of biomedical research programs directed toward specific diseases be evaluated in the context of: the relative priority of the new programmatic focus in relation to ongoing programs; the appropriate distinction between research and non-research components of the proposal; the status of the scientific understanding of the disease and the potential for progress of a targeted approach; and the suitability of existing legislative authorities for the accomplishment of newly identified objectives.

The Association this year reiterated its belief that the key to our ability to achieve long-term biomedical research goals is the maintenance of a strong program of fundamental research such as is supported by the National Institute of General Medical Sciences. The Association has continued to oppose vigorously proposals which would undermine this basic concept.

Health Care

Through a variety of programs, the Association carries out its responsibilities in assisting the academic medical centers in the development of improved health care systems. These activities are conducted with advice and counsel from the Health Services Advisory Committee.

During the past year, the AAMC completed a project providing technical assistance and consultation to five prototype developing health maintenance organizations associated with academic medical centers. The experience of the prototypes will be valuable to other institutions involved in the development of HMOs. As a corollary to this project, the Association has recently initiated a program to develop model curricula for physician training based upon the medical practice requirements of health maintenance organizations. This study will provide insights into the ways to involve students with the least interference with the basic concepts of this form of health care delivery. Six representative institutions will be selected to participate in the 21-month study, which is supported by a contract with the Bureau of Health Resources Development, Department of Health, Education, and Welfare.

The development of techniques for quality of care measurement and related educational efforts are gaining increasing importance as Professional Standards Review Organizations become established nationally. The Subcommittee on Quality of Care of the Health Services Advisory Committee has reviewed the results of an AAMC survey of teaching hospitals and medical schools measuring the development of formal programs for medical students in quality of care processes and the degree of involvement of academic medical centers in local PSRO development. The subcommittee has continued to stress the importance of such involvement, and meetings with members of the Office of Professional Standards Review, DHEW, and the Bureau of Quality Assurance, SSA, have been scheduled to enhance this effort in a collaborative fashion. A program focusing on opportunities for medical research, medical service, and medical education activities within the PSRO legislation has been scheduled

for the AAMC Annual Meeting in November 1974.

The degree of commitment of the medical schools and teaching hospitals to educational programs related to primary care has been documented by a survey conducted during the summer of 1973. The data from this survey, published in the September 1974 issue of the *Journal of Medical Education* (49:823-33, Sep 74), indicate that one-half of all the medical centers have made major changes in primary care education during the past three years, that one-half of the institutions now have programs for graduate level training in family medicine, and that two-thirds of all the academic medical centers are now involved in the training of new health care practitioners. The AAMC Task Force on Primary Care has promoted a number of activities including the half-day program on primary care presented at the AAMC Annual Meeting in November 1973. Judging from the response to this symposium, the need for a further exchange of information among academic medical centers on the development of primary care programs became apparent.

The Task Force has subsequently developed plans for an AAMC Institute on Primary Care to be held in October 1974. Participation in this Institute is being encouraged particularly among chairmen and faculty of departments of medicine and pediatrics. Included among the issues to be addressed are the development of newly organized model systems of care, interrelationships between departments of medicine, pediatrics, and family medicine, and the training of new health professionals. The Institute is being supported by the Bureau of Health Resources Development, The Commonwealth Fund, the Kaiser Family Foundation, and The Robert Wood Johnson Foundation.

Following the Institute, a series of six regional workshops will be held. In each of these workshops, invitees from area medical schools and teaching hospitals will share experiences in greater depth and explore in more detail the most effective ways to increase the number of primary care physicians.

Faculty

The Association has established a Division of Faculty Development as part of the Department of Academic Affairs. In an effort to assist medical school faculty members in carrying out their educational responsibilities, this Division will sponsor programs and workshops aimed at developing effective instructional strategies and improving methods of evaluating student performance.

The Association's Faculty Roster project, financed under a contract with the Bureau of Health Resources Development, has become increasingly useful in answering questions relating to faculty composition, mobility and retention. The Roster was initiated in 1965 in order to inventory the intellectual capital of medical education, to study the sources of faculty and the circumstances of their training, and to characterize the flow of persons from one institution to another and the reasons for departure from academic medicine. It is the only comprehensive project of its kind and has been particularly concerned with the development of manpower to staff new and expanding medical schools. The medical schools are now being provided systematic and organized reports of their own Roster data to enable them to use the system as a faculty data base at the institutional level.

In addition to the record keeping capabilities of the Faculty Roster, it has provided the Association with the necessary data base to engage in analytical studies of medical school faculty. Work is currently underway to study faculty mobility, to examine the impact of federal support programs on faculty and institutions, and to determine the participation of women as medical school faculty members.

As part of the work of the Committee on the

Financing of Medical Education, an examination of the manner in which faculty allocate their effort was conducted. The Committee was well aware that the instructional cost of the undergraduate M.D. program is only one part of the full educational cost. An analysis of a group of faculty effort reports in conjunction with the best judgment of a panel of medical educators was directed toward the development of a model faculty member "fully involved in education." The effort of the faculty members at the schools under study was then related to the model in order to estimate the cost of the research and clinical activity components of the educational program leading to the M.D. degree.

Results from the 1973-74 Medical School Faculty Salary Study were released in May by the Association. Conducted annually, this study has continued to provide medical school administrators, faculty chairmen and others with a valuable tool for reviewing faculty salary trends. The number of individuals covered by this year's survey increased dramatically over the previous year—from 16,492 (105 schools) to 27,830 (106 schools) full-time faculty members. The total number of full-time faculty members is approximately 35,000.

Support is being sought to launch a Visiting Professors Emeriti program. This idea has been developed in response to the medical schools' need to increase their health manpower resources in the face of a constricting financial picture. Under this proposal, the AAMC would act as a clearinghouse, providing the administrative coordination of matching the volunteer faculty to the host schools. Any commitments beyond this would be the responsibility of the individual and the institution involved.

Students

The extraordinary pressure for admission to American medical schools continued to be a major concern of the Association this year. There were 40,507 applicants for 14,124 positions available in American medical schools for the 1973-74 entering class. That this pressure will continue is evidenced by the registration of 32,159 candidates for the May 1974 MCAT; this compares with 29,715 registered in May 1973. The Association strives to assist both the applicants and the schools so that students may be selected for admission equitably and fairly.

Eighty-three schools now participate in the American Medical College Application Service. Through this service, applicants submitted 268,090 applications for the 1974-75 entering class. The filing of a single application on a standardized form by the students and the provision of transcript verification and grade interpretation services by AMCAS has greatly facilitated the admissions process. In addition, AMCAS now generates monthly reports on the status of admissions in the nation's medical schools. Periodic reports are also generated for college advisors. These reports summarize national application and admission activity and provide information on applications filed by the subscribing undergraduate college's students.

Through an Early Decision Plan, in which 51 institutions participated, 628 students were admitted without filing an application to any other school. As a result, these applicants and the medical schools were spared the processing of almost 5,000 applications which the students would otherwise have filed.

At the specific request of the Council of Deans, and with partial support from the Kaiser Family Foundation, a pilot admissions matching plan was tested in California and Michigan; all schools in these two states participated. The final evaluation of this matching plan, which was conducted in parallel with the normal admissions procedures, has not yet been completed. Should the experiment be determined successful, consideration will be given to limited operational trials for the selection of the 1976-77 entering class.

The Association continued its efforts to increase the number of minority students selected for medicine. The Medical Minority Applicant

Registry was twice distributed to the medical school admissions officers. In addition, a training device for those involved in selecting students, the Simulated Minority Admissions Exercises, was developed and refined through a series of regional workshops. The exercise workbooks and manuals are now being published for utilization by admissions officers and admissions committees in the medical schools.

The Association filed an *amicus curiae* brief on behalf of the defendant, the University of Washington, in the case of *De Funis v. Odegaard*, which was heard by the U.S. Supreme Court. This case was of major significance in relation to affirmative action efforts directed toward selecting minority students for medicine. The plaintiff, a nonminority University of Washington Law School applicant, alleged that minority students who were less qualified than he were admitted solely on the basis of race, constituting discrimination. The Supreme Court did not rule on the merits of the case, judging it moot because the student, who had been admitted in 1971 by court order, was about to graduate. Since the Supreme Court's decision, several similar suits have been filed in various parts of the country, some of them by medical school applicants. The dilemma created by the Federal requirement that the schools demonstrate affirmative action efforts while potentially subject to suit for reverse discrimination must ultimately be resolved by the courts. Meanwhile, the Association is studying all aspects of the problem in order to advise the institutions regarding their admissions procedures. Litigation by students directed at the institutions where they are attempting to enroll is becoming increasingly common.

Securing sufficient financial aid for medical students has been a major concern of the Association. In its testimony before Congress, the Association strongly recommended that Federal grants-in-aid and loans to medical students be continued through the Bureau of Health Resources Development and that the annual limitation on grants-in-aid be increased from \$3,500 to \$4,500. The Association also supported provisions for loan forgiveness for students who choose to serve in the National Health Service Corps or practice in a

health shortage area.

Four regional workshops directed toward improving the administration of financial aid services to the students by the institutions were held during the Spring of 1974. Over one hundred medical school financial aid officers attended these workshops. Discussion topics included national and local financial aid policies, technical problems related to record-keeping and needs analysis.

The Coordinated Transfer Program for U.S. citizens studying medicine abroad continued to expand. Through COTRANS, 957 students took the Part I examination of the National Board of Medical Examiners; 292 passed. Since the inception of the program in 1970, 2,340 students have

been tested, 686 have passed the exam and 546 have enrolled in U.S. medical schools. There has been a steady increase in the number of students and schools utilizing COTRANS.

The Group on Student Affairs held a planning conference in February of 1974 in Chicago. Specific areas of major concern were identified and it was recommended that the GSA and the Association focus on problems related to medical student financial aid, admissions policies, data acquisition and confidentiality, student personnel administration, the legal problems faced by student affairs officers, and the special needs of the professional student affairs officers and advisors.

Institutional Development

The Management Advancement Program has been in operation for two full years. This program, maturing with the deep involvement of representatives of the Council of Deans under the direction of a steering committee chaired by Dr. Ivan Bennett, has sought to enhance the leadership qualities and skills requisite to the task of creative institutional development.

The program consists of three seminars. The first, an Executive Development Seminar (Phase I) for the dean or the principal executive officer of the medical school, is a one-week workshop on management technique and theory conducted for a maximum of 25 participants by faculty from the MIT Sloan School of Management. The second, a follow-up Institutional Development Seminar (Phase II), is conducted three months to a year following the Phase I seminar. The dean, who has completed the Phase I seminar, selects a group of colleagues to join him in Phase II. He and his colleagues review some of the concepts and informational input from the first seminar and have an opportunity to apply some of these concepts to a problem of concern to the institution.

The first Phase III Seminar was held in June of 1974. This seminar, for which Phase II is a prerequisite, was designed to increase the capability within the medical schools in applying problem solving techniques. In addition to further exposure to management concepts and skills, Phase III provides extended team time for actual problem-solving sessions.

Underlying the design of the program is the perception that the leadership of the academic medical center and its component institutions can benefit greatly from an enhancement of their technical managerial skills and a refinement of their human relations or behavioral skills. This is coupled with a recognition of the necessity of broadening the base of interest in improving the managerial quality within individual schools. Thus, not only the principal manager or executive is involved, but a whole group of those concerned with the development of the institution and its programs. The need for follow-up and reinforcement is also recognized and accounts for the iterative nature of the program.

With the fourth Phase I, 82 deans will have par-

ticipated in the Executive Development Seminars. The follow-up seminars have involved 37 institutions in Phase II and 7 in Phase III. Over 286 individual participants have attended. In addition to the deans, 63 department chairmen, 19 hospital administrators, 13 vice presidents, 2 chancellors, and a considerable number of business officers and planning coordinators have attended.

Closely related to these efforts has been the assistance provided to the Group on Business Affairs and the Planning Coordinators Group in the development of their professional educational programs, patterned after the conceptual framework of the Management Advancement Program. Such coordination insures an understanding of the interdependent goals of these different programs.

In support of these activities and the goal of institutional renewal is a series of descriptive and analytic studies of the academic medical center now underway. A Delphi forecast of the future of medical education as perceived by the deans has been completed. A file of documents relating to the governance of the schools has been established, from which such matters as the organizational structure and governance processes can be examined. Specific areas which have been studied include the process and authority for the appointment of deans and department heads, and procedures for appointment, promotion, award of tenure and dismissal of faculty members. Also under examination is the status of collective bargaining in higher education and its implications for medical school faculties. Ongoing efforts are underway to identify from the literature and facilitate the outside development of additional studies of significance to medical center management.

As a result of legislation directed at assuring equal opportunity for women and minorities in the educational process, all medical schools have been required to provide data and undertake an analysis of personnel policies which will demonstrate nondiscriminatory practices. The institutions are required by law to correct any practices which are found to be discriminatory. In order to assist the institutions to meet these requirements, the Association has been attempting to identify appropriate models for data collection

and documentation of personnel procedures, and means for assuring the provision of due process. In conjunction with this, there have been communications with representatives of the Office of Civil Rights, the Equal Employment Opportunity Commission, the Wage and Hour Division of the Department of Labor, and the Department of Justice to maintain current information with respect to new or revised requirements and regulations.

An additional activity has been active participation in an inter-association Equal Employment Opportunity Task Force, staffed by the American Council on Education. This has provided the opportunity to develop in conjunction with other educational associations a series of recommen-

dations to the Federal agencies responsible for the development and implementation of the requirements and penalties.

The Association collects and analyzes data describing the status of women applicants to medical schools, women faculty members at U.S. and Canadian medical schools, and the cohort of women physicians who are participants in a longitudinal study which began in 1956. Additionally, participation in a number of conferences for professional women has provided a forum for formal and informal exchange of information related to the impact of increasing the numbers of women in medicine and other health professions, and in the more general category of non-traditional fields.

Teaching Hospitals

The past year witnessed heightened governmental activity aimed at regulating the health industry. Considerable Association activity was directed toward analyzing and responding to legislation and regulations dealing with hospital controls.

In response to regulations regarding the payment of teaching physicians under Medicare, (Section 227, P.L. 92-603), the staff conducted studies of reimbursement at six medical centers. These studies resulted in a report which was instrumental in delaying the implementation of Section 227 pending a more thorough analysis of the issue by the Institute of Medicine of the National Academy of Sciences.

Proposed regulations seeking to implement Section 223 of P.L. 92-603 were published in May of 1974. These regulations, which were finally adopted in June, subdivided all short-term general hospitals into seventy groups within which per diem routine service costs were limited. Staff developed an analysis of the Social Security Administration's grouping methodology, employing data provided to the Association by the SSA. This analysis concluded that the proposed regulations sought to implement an overly simplistic mechanism which had the capability to deny reimbursement for costs that were in every way reasonable. Empirical analyses demonstrated that the hospital groups established in the regulations were no better than random groupings. Although final regulations were issued for a period of one year, the classification methodology employed by SSA to group hospitals will be subject to further scrutiny. The Association will be working with the Bureau of Health Insurance in their efforts to develop a more refined classification methodology during the next twelve months.

The AAMC also responded to proposed regulations seeking to implement other sections of the Social Security Amendments and directly affecting teaching hospitals. Association comments were filed regarding: Section 2991 payment

for services in connection with kidney transplant and renal dialysis; Section 233, amount of payments where customary charges for services furnished are less than reasonable cost; Section 237, regulations specifying utilization review procedures under Medicare and Medicaid; Section 208, rules regarding the implementation of cost sharing under Medicaid; and Section 221, limitation of federal participation in capital expenditures by hospitals.

In response to a request by the Joint Commission on the Accreditation of Hospitals, the AAMC organized a task force to review and analyze the 1973 revisions of the JCAH Standards. Among the areas included in the task force report were governance format, medical staff role in institutional patient care decisions, medical staff appointment qualifications, house staff participation in quality assurance, and innovation in teaching hospitals. Because of this initial work with the Commission, the staff has been asked to follow through by reviewing the model medical staff bylaws for their applicability and relevance to teaching hospitals.

Preliminary results are expected within the coming year from a survey and analysis effort designed to examine the organizational and functional arrangements of computer services in university-owned teaching hospitals. The Association is seeking support for a research project to analyze the differential utilization of ancillary services in three groups of teaching hospitals classified by their involvement in medical education.

Foundational work is being undertaken to design a project whereby the costs and production functions of teaching hospitals can be more rigorously specified. It is hoped that this effort will assist in more rigorously quantifying the impact of hospital participation in educational programs on cost. An initial output of this project is an annotated bibliographical review summarizing efforts to document the relationship between involvement in medical education and cost.

Communications

The Association communicates its views, studies, and reports to its constituents, interested Federal representatives, and the public through a variety of publications, news releases, press conferences, and personal interviews. The major communications vehicle for keeping the constituents informed is the President's Weekly Activities Report. This publication, which is issued 43 times a year and reaches more than 3,000 subscribers, reports on AAMC activities and Federal activities that have a direct effect on medical education, biomedical research, and health care.

The *Journal of Medical Education* continued to expand during the past year. The *Journal* published 1,331 pages of editorial material during this period compared with 1,288 pages the previous year. The proceedings of a Fogarty International Center Conference, "Medical Education and Medical Care: A Dynamic Equilibrium," were published as Part 2 of the December 1973 issue. The regular issues carried three supplements during the year: "Guidelines for Academic Medical Centers Planning to Assume Institutional Responsibility for Graduate Medical Education" (48:779-91, Aug 73); "Survey and Evaluation of Approaches to Physician Performance Measurement" (48:1051-93, Nov 73); and "Undergraduate Medical Education: Elements, Objectives, Costs" (49: 101-28, Jan 74). Other regular issues carried special sections on cost and management and on the use of computers in health science centers. The plenary addresses from the 1973 AAMC Annual Meeting and the 1973 AAMC Proceedings and Annual Report also were published in the *Journal*.

The *Journal's* monthly circulation is about 6,500. Excluding the supplements and the Part 2 magazine, a total of 154 papers (90 regular articles and 64 Communications) were published, compared with 151 papers the previous year. 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* in 1973-74 received 397 manuscripts for consideration. Of these, 140 were accepted for publication, 169 were rejected, 17 were withdrawn, and 71 were pending as the year ended. In the previous year, 359 papers were received.

The *AAMC Bulletin*, which contains news items from the schools, the Association, the government, and related fields of education, circulated almost 7,000 copies a month. In addition to the *Bulletin*, other newsletters of a more specialized nature are: *AAMC Education News* (which is sponsored by The National Fund for Medical Education), *The Advisor*, *COTH Report*, and *Student Affairs Reporter*. About 40,000 copies of the annual *Medical School Admission Requirements*, 4,000 copies of the *AAMC Directory of American Medical Education*, and 3,500 copies of the *AAMC Curriculum Directory* were sold or distributed. Numerous other publications such as directories, reports, papers, studies, proceedings, and archival listings, also were produced and distributed by the AAMC.

The Educational Press Association of America cited three articles in two AAMC publications to receive "EdPress Awards for Excellence in Educational Journalism." Cited were an editorial in the *Journal of Medical Education* and a feature and news story in the *AAMC Bulletin*.

The Group on Public Relations, which represents the public information officers of the medical schools and teaching hospitals, made progress on its two primary projects for the year—Med-Aware and the development of Patient Information Guidelines.

The public increasingly gets its information from what is commonly called the electronic media, television and radio. Med-Aware is aimed at taking advantage of the public's viewing and listening habits to reinforce the need for continuing support of medical research and education. Patient Information Guidelines are being developed for use in handling the VIP patient, particularly the newsworthy public figure.

Information Systems

The Association is developing a comprehensive and integrated information system, which will include data on students, faculty and institutions. The junction of these components will permit summary information from the person-oriented data bases to be included as institutional data and will permit studies of faculty or students to take into account the characteristics of the institutions with which they are associated.

The data on applicants and students includes biographic and demographic information, as well as measures of academic achievement and application activity. It is regularly analyzed and reported in the "Study of U.S. Medical School Applicants," published annually in the *Journal of Medical Education*. Special reports are also made on such subjects as retention and testing activity.

Data on medical school faculty includes biographic information as well as present appointment, employment and educational history, and information on past or present participation in federal programs. The data is used to provide a roster and descriptive statistics to each medical school, as well as to support research on faculty development, mobility, and attrition.

The Institutional Profile System was designed to bring organization and accessibility to the collection, storage, and retrieval of AAMC institutional data in order to facilitate: (1) service to the constituency through comparative inter-institutional feedback; (2) a comprehensive institutional data system for staff and outside user needs; and (3) inter-institutional research targeted at improving the conceptualization of the medical education system. Data now included or planned for inclusion in this system includes all AAMC data on medical schools and teaching hospitals.

In addition to flexible and accessible information organization, the system presents the capability to generate computer reports uniquely tailored to an individual institution or to groups of institutions. These reports contain descriptive, ranking, or statistical summary information facilitating inter-institutional comparisons.

Analytic studies and evaluations of the available data supplement these ongoing reporting activities. For example, institutional dissimilarities manifested in the data have prompted the development of a "sister-school" or "sister-hospital" algorithm which scales institutions in terms of uniqueness and identifies for any institution those other institutions which exhibit similar data patterns.

The Association continues to serve as an information resource for teaching hospitals with respect to the dissemination of medical school affiliation agreements, bibliographies on topics of special interest, relevant court decisions affecting teaching hospitals, Internal Revenue Service rulings concerning house staff stipends, comparative revenue and expense data, and analyses of collective bargaining trends.

For the sixth successive year, the Survey of House Staff Policy was conducted. The survey is designed to compile information regarding the relationship between teaching hospitals and house officers and serves as one of the most comprehensive sources of data on stipends and fringe benefits. A five-year analysis of house staff salaries was undertaken in an attempt to construct a model explaining factors that influence the variability of salaries among hospitals and in the same and in different years; an article reporting the findings of this study will appear in the *Journal of Medical Education*.

The sixth annual survey of teaching hospital executive salaries is in the data collection stage and results will be disseminated in early December. An analysis of trends in executive salaries across the last five years was mailed to participants in the survey during August.

The Association has continued its study of university owned and/or operated teaching hospital income and expense although under a revised format. This year the questionnaire was designed to abstract relevant data from the Medicare Cost Report filed by each hospital. The innovation is expected to produce more comparable analyses.

Treasurer's Report

The audited statements and the audit report for the fiscal year ending June 30, 1974 were carefully examined by representatives of the Association's auditors, Ernst & Ernst, representatives of the Association's legal counsel, Williams, Myers and Quiggle, and members of the Association's Audit Committee on August 30, 1974. At its meeting in Washington on September 20, 1974, the Executive Council reviewed and accepted the final audit, which was unqualified except for possible legal liability under pending litigation concerning score reporting for the Medical College Admission Test. The management letter accompanying the audit report indicates that the Association's fiscal and internal control systems are adequate and minor recommendations for their improvement have already been implemented. The auditors expressed satisfaction with the performance of the accounting staff, with the quality of the accounting records and procedures, and with the excellent cooperation of the staff during the course of the audit.

Total income for the year increased 20.84% to \$7,562,371. Added volume of activity in special

projects accounted for 33% of the increase, with contracts and grants providing 45%, membership dues 1%, and other items including interest income, annual meeting income, and miscellaneous receipts 21%.

Expenditures and transfers to restricted funds for special purposes totaled \$6,508,597. 50.5% of the increase in expenditures was in grants and contracts and 49.5% in other Association programs.

Balances in funds restricted by grantor increased \$153,500 to \$580,531 while unrestricted funds available for general purposes increased \$1,037,081 to \$3,089,407—a reserve equal to less than 6 months operations at the 1973-74 level of expenditures.

As the Association continues to expand its services and given the uncertainties of the sources of the Association's future financial support, the continuation of reserve accumulation is appropriate and should be continued until such a time as unrestricted reserves are approximately equal to one year's operating expenses.

TREASURER'S REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES BALANCE SHEET June 30, 1974

ASSETS

Cash	\$ 136,286
Certificates of Deposit	3,600,000
Accounts Receivable	1,179,420
Deposits & Prepaid Items	19,761
Investments in Management Account	813,187
	<u>\$5,748,654</u>

LIABILITIES AND FUND BALANCES

Liabilities	
Accounts Payable	361,560
Deferred Income	787,397
Fund Balances	
Funds restricted for special purposes	1,213,434
Funds restricted to investment in plant	296,856
General Funds	3,089,407
	<u>\$5,748,654</u>

OPERATING STATEMENT

Fiscal Year ended June 30, 1974

SOURCE OF FUNDS

Income	
Dues & Service Fees from Members	\$1,427,059
Grants Restricted by Grantor	549,266
Cost Reimbursement Contracts	1,789,390
Special Services	3,050,428
Journal of Medical Education	60,394
Other Publications	174,569
Sundry	511,265
	<u>\$7,562,371</u>
Reserve for MCAT Development	131,016
Reserve for Special Minority Programs	5,791
	<u>\$7,699,178</u>

USE OF FUNDS

Operating Expenses	
Salaries & Wages	\$2,598,949
Staff Benefits	343,210
Supplies & Services	2,829,526
Equipment	67,472
Travel	569,440
	<u>\$6,408,597</u>
Transfer to Restricted Funds for Special Purposes	100,000
Increase in Restricted Funds Balances	153,500
Increase in Unrestricted Funds Balances	1,037,081
	<u>\$7,699,178</u>

AAMC Membership

TYPE	1972-73	1973-74
Institutional.....	101	105
Provisional Institutional.....	14	10
Affiliate.....	15	17
Provisional Affiliate.....	2	0
Graduate Affiliate.....	1	1
Academic Societies.....	51	56
Teaching Hospitals.....	390	394
Individual.....	2,233	2,243
Emeritus.....	65	63
Contributing.....	13	13
Sustaining.....	15	15

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