

**Association
of
American
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14-75

REPORT — ACCURACY

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President's Message

In a recent thoughtful and perceptive article in the *New England Journal of Medicine*, Howard Hiatt asked who is responsible for protecting the medical commons? Who will allocate the finite resources available to achieve the greatest benefit to society?

Before the paper was published, the Congress provided its answer to the query in the National Health Planning and Resources Act of 1974, which was signed into law by President Ford in January 1975. It has been called the most important piece of health legislation since the enactment of Medicare. Although the act extensively revised and greatly strengthened health planning programs at the national, state, and local levels, its implications have not been widely understood by the academic medical centers. Among its major provisions is the requirement that the Secretary of Health, Education, and Welfare, with the assistance of a National Council on Health Planning, establish national health priorities. On the basis of these priorities, guidelines for planning goals are to be prepared for area Health Systems Agencies, State Health Planning and Development Agencies, and Statewide Health Coordinating Councils for their use in allocating resources for health services and the education of health professionals.

Problems in implementing the act are already apparent. Politics have intruded into the designation of planning areas and the development of the state planning and regulatory agencies. The number of qualified professionals required to carry out the far-reaching provisions of the act are unavailable. The difficulties encountered in coordinating new planning groups with existing regional and state planning agencies almost assure multiple and conflicting directives that will add to the present dilemma of institutions in conforming to contradictory mandates and regulations.

There are other problems. The act exempts federal research grants and contracts and the support of health professional education and training from the requirement of approval by state and local agencies unless they are used to support the development of resources intended for use in the health service area or the delivery of health services. There are a number of existing programs which fall into gray areas, such as cancer control programs, which will lead to controversy and friction. It is not reassuring that some Health Systems Agencies have already made moves to establish approval authority over federal support for biomedical research and health professional education and training. Serious threats to the important concept that medical schools are national resources are posed by placing their programs under the jurisdiction of agencies that may represent narrow, parochial interests. Furthermore, their interests will be compromised by the certain tendency of the local agencies to emphasize short-term solutions to problems without adequate consideration of long-term consequences.

Although the act recognizes the unique contributions of academic medical centers in education, research, and the provision of complex health services, it does nothing to eliminate competition between the programs of these institutions and the more immediate and seemingly pressing needs for preventive care and routine curative medicine. There is no assurance that the voices of the academic medical centers will have any great impact on establishing national priorities or the development of rational planning mechanisms under which they can continue to make their unique contributions. They will have to fight hard to have any of the commons for their herds.

Howard Hiatt said in his view, "It is essential that society create mechanisms that separate the demands on the commons of research and education from those of medical care, for these should not be forced to compete with each other on a continuing basis." Apparently the majority of the herdsmen did not agree with this conclusion and we will have to compete with the more voracious cattle grazing on the green.

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

President's Message

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.

The Annual Retreat of the elected officers was held in December prior to the first meeting of the new Executive Council. The Retreat participants reviewed and discussed several key issues confronting the Association, including AAMC organization and governance, relationships with other organizations, ongoing staff activities and space requirements, physician production and distribution, the implications of national health insurance for medical education, and several areas of proposed staff activity. The Retreat participants concurred in the appointment of a Health Manpower Task Force, chaired by Dr. Daniel C. Tosteson, charged to recommend to the Executive Council an appropriate Association stance on pending health manpower legislation and provisions to affect geographic and specialty distribution of physicians.

The Executive Council approved the report of the Officers' Retreat and, in a major policy statement, approved the report of the Health Manpower Task Force. With this policy the Association reaffirmed its belief that basic support should be provided to medical schools on the basis of enrollment, that additional institutional support should be provided if the institution agreed to undertake certain initiatives aimed at increasing enrollments, providing more opportunities for primary care training, or influencing physicians to practice in underserved areas. The Association also went on record in support of restricting the number of foreign medical graduates admitted to practice in this country and appointing the Coordinating Council on Medical Education or a similar national advisory group to review and approve graduate training programs in order to assure the appropriate distribution of residency programs by specialty.

Another major policy consideration during the past year has been the Association's review of the Report of the Committee on Goals and Priorities of the National Board of Medical Examiners. In carefully considering the GAP Report recommendations, which have broad implications for the examination and licensure of U.S. physicians, the Executive Council received input from the Council of Deans, the Council of Academic Societies, the Organization of Student Representatives, the Group on Medical Education, and an AAMC task force. The Executive Council has developed an Association response to the GAP Report and will present this response to the AAMC Assembly.

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. This year the Executive Council approved a CCME statement on "The Role of the Foreign Medical Graduate," which embodied the recommendations of a CCME-sponsored National Invitational Conference on the Foreign Medical Graduate. This position was consistent with the previously adopted AAMC policy on foreign medical graduates.

In a related action, the Executive Council approved a statement recommending to the medical schools that where resources were available, qualified U.S. citizens who had studied medicine abroad should be admitted into the regular educational program leading to the M.D. degree. The admission, placement, and certification for graduation of these students should be subject to the academic policies of the faculty of the institution. It was recommended that this program supersede existing Fifth Pathway programs.

The Association's policy on national health insurance was reviewed by a small committee of the Executive Council in light of several recommendations forwarded by the Coordinating Council on Medical Education. On the recommendation of this committee, the Executive Council reaffirmed its previous position, emphasizing several aspects of that position, and adopted a response to the CCME recommendations.

Following the passage of the Health Planning and Resources Development Act in late 1974, the Executive Council appointed a task force to identify and respond to issues of concern to the schools and

teaching hospitals as DHEW began the process of writing regulations. The Council reviewed and endorsed the task force's response to a DHEW request for comments on planning agency review of the use of federal funds for health manpower training and biomedical research.

The Executive Council authorized the President and the Association's attorneys to participate in several legal actions during the year. The AAMC filed suit in U.S. District Court seeking to enjoin the implementation of regulations establishing ceilings on Medicare reimbursement for routine hospital service costs. The Association has appealed the District Court judge's denial of the motion for an injunction.

The Association also filed an *amicus curiae* brief with the National Labor Relations Board on behalf of five member hospitals, urging that the Board not extend its jurisdiction to housestaff bargaining units. The AAMC asserted the educational nature of internships and residencies, pointing out that recognition of housestaff collective bargaining units would have a detrimental effect on the structure, function, and content of graduate medical education.

The Executive Council continued to review carefully the work of the Liaison Committee on Medical Education and the Liaison Committee on Graduate Medical Education, the accrediting agencies for undergraduate and graduate medical education programs. The Council approved and forwarded to the LCME a statement requesting stricter enforcement of the LCME accreditation standards, including denial of accreditation to educational programs of submarginal quality. The Council also adopted a statement asking the LCGME to undertake the difficult task of defining the pathways into graduate medical education. The Coordinating Council on Medical Education was asked to assume the responsibility of authorizing the formation of new specialty boards and the development of accreditation programs for new specialties.

The AAMC Bylaws authorize the Executive Council to develop criteria for each class of membership in the Association. The Council revised its criteria for Provisional Institutional Membership to require provisional accreditation by the LCME; previously, schools with a letter of reasonable assurance of accreditation had qualified. The Council also approved new criteria for teaching hospital membership and recommended to the Assembly a Bylaws change which would allow some hospitals not qualified for COTH membership to become Corresponding Members of the Association.

The Executive Council approved and recommended to the Assembly another Bylaws change which would allow schools to designate a second representative to the Organization of Student Representatives if their first representative had been elected to the Administrative Board. This change would provide added continuity to the OSR governing board by allowing its elected members to serve a full term.

In other actions, the Executive Council approved a revised and expanded Affirmative Action Program for the Association, supported the concept of a national data base for the health professions, agreed to discontinue publication of the *AAMC Bulletin*, and approved a statement recommended by the Group on Student Affairs asking the schools not to notify non-Early Decision Plan applicants of acceptance prior to November 15.

The Council's Executive Committee met prior to each Executive Council meeting and by conference call on numerous occasions throughout the year. The Committee also held meetings with Senator Edward Kennedy, Representative Paul Rogers, Counselor to the Vice President John Veneman, DHEW Assistant Secretary for Health Dr. Theodore Cooper, DHEW Assistant Secretary Comptroller John Young, and Commissioner of Social Security James B. Cardwell. In April the full Executive Council met with members of the President's Biomedical Research Panel to discuss broad perspectives on research funding priorities.

The Executive Council along with the AAMC Secretary-Treasurer, Executive 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 1976.

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. The Administrative Board also considered the Report of the AAMC Pilot Medical School Admissions Matching Program and recommended that the study and implementation of a matching program be discontinued at this time. In taking this action the Board also urged that all medical schools continue monitoring and refining admissions policies and procedures. The Board considered and approved the OSR Rules and Regulations revisions regarding OSR Administrative Board selection and

THE COUNCILS

membership and provisions for formal action at the OSR regional meeting level. The Council of Deans Administrative Board also reviewed a revised questionnaire for the Annual Survey of Deans' Compensation, which was expanded to include additional factors which might have a bearing on compensation.

At its November business meeting, the Council discussed AAMC health manpower policy and heard a report of the Coordinating Council on Medical Education on the role of the foreign medical graduate. The Council also heard a report of the AAMC Task Force on the Goals and Priorities (GAP) Committee Report of the National Board of Medical Examiners. Discussion of the Task Force Report was postponed until the April business meeting in Key Biscayne, Florida.

The Council's spring meeting continued the recently established tradition of a two and one-half day retreat, considering a series of problems of concern to deans. The theme was "Academic Decision-Making: Issues and Evidence." The purpose of the meeting was to give the deans a theoretical framework and an understanding of successful approaches to assessing student, faculty, and program quality and to heighten the deans' awareness of resources and methodologies available for academic decision-making. In the area of student assessment, the deans received a series of thoughtful presentations on information systems for monitoring student performance, evaluation of problem-solving skills, and clinical performance assessment through record audit. As part of the faculty assessment portion of the program, the deans participated in a simulated decision-making exercise in which they had to make choices about awarding of faculty tenure. In the third portion of the program, devoted to an examination of program evaluation, the speaker placed selected educational outcomes in perspective for the deans. At the business session which followed the program, the deans considered the AAMC Task Force Report on the Recommendations of the NBME GAP Committee, and examined each of the GAP Committee's major recommendations in light of the Task Force's response and the subsequent reaction of the Council of Academic Societies and the Organization of Student Representatives. The Council recommended that the existing three-part system not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education. Other recommendations concerned the development of a qualifying examination for entrance into programs of graduate medical education, the role of the LCGME in implementing such

an examination, and the role of specialty boards in the licensure process.

The Council also recommended that AAMC staff continue to develop and implement a proposed survey, whose open ended format would be similar to last year's Delphi survey, to identify institutional governance issues.

Concurrent with the spring meeting, the President's Biomedical Research Panel met in Key Biscayne and invited the Council of Deans to attend and provide testimony. Six key biomedical research issues relevant to the academic medical center were identified by the Council for presentation before the Panel: (1) the problem of the institutional setting for biomedical research; (2) the problem of institutional overhead costs; (4) the impact of centers for targeted research; (5) the resources that biomedical research provides; and (6) the organization of the federal research enterprise. Copies of the presentations were submitted to the Panel and subsequently distributed to the Council of Deans and Council of Academic Societies for their information.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies held two national meetings during the year. The Administrative Board of the Council met quarterly and acted on behalf of the Council on all issues presented for the consideration of the Executive Council.

The CAS joined the COD and COTH in sponsorship of a half-day program at the annual meeting on the problem of "Specialty Distribution of Physicians." Featured speakers presented points of view of the Congress, the Administration, and the private sector. This topic was extremely timely in view of national concerns and legislative considerations.

During its fall business meeting the CAS held a detailed discussion of the AAMC Task Force Report on the Goals and Priorities Committee recommendations to the National Board of Medical Examiners. The CAS agreed with the concept of a universal qualifying examination, to be required of all students prior to entering graduate medical education, but strongly recommended that the present Parts I, II, and III of the National Boards not be abandoned until such time as the new qualifying exam has been thoroughly tried and its validity determined. The Council also strongly recommended that the Liaison Committee on Medical Education require that in the process of accrediting medical schools, data on student achievement acquired from external evaluations be provided to the accrediting team. This recommendation grew out of a serious concern by the CAS

that the basic and clinical sciences content of medical education not be further eroded. The Council also recommended that the results of the qualifying exam be transmitted to the medical schools and to the graduate programs to which students are applying.

The CAS discussed at length proposed legislation to extend health professions educational assistance. The Council voted unanimously to support a recommendation of its Administrative Board that the AAMC vigorously oppose any bill which would threaten the integrity of undergraduate and graduate medical education. It was further recommended that the schools actively seek alternate sources of funding to preserve their role in developing and assuring the quality of educational programs.

Thirty-nine academic societies were represented in a two-day CAS spring meeting. The President's Biomedical Research Panel met with the Council and was informed of the problems facing the biomedical research community with the instability in research funding and program direction. The Panel members were told that unstable support for research training grants poses a real threat to the future of biomedical research.

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.

The amendment of the National Labor Relations Act to include all non-public health care facilities was a key issue confronting many of the COTH members. Petitions filed by housestaff organizations seeking recognition as collective bargaining agents presented new and unique problems to the hospital administrators. To assist the hospitals in understanding the requirements of the law, the Council sponsored a one-day Workshop on Housestaff Collective Bargaining in place of its regional meetings. Presentations were made by experts in the field of labor law and by hospital representatives experienced in this area.

The revision of criteria for membership in COTH was considered at length by the Administrative Board and by an ad hoc committee chaired by David D. Thompson, M.D. The committee's recommendations, which included a proposal to establish a category of non-voting Corresponding membership, were approved by the Administrative Board and Executive Council and will be reviewed with the full Council of Teaching Hospitals at its annual meeting.

The COTH Administrative Board was particularly

active this year in working with the Executive Council and the Association's attorneys on constraints imposed by the 1972 Social Security Amendments (P.L. 92-603). As a result of these activities, the Association filed a lawsuit to enjoin the implementation of regulations setting ceilings on Medicare reimbursement for routine hospital service costs. The Board also monitored regulations issued on Medicare cost reimbursement, utilization review, and elimination of the nursing differential.

ORGANIZATION OF STUDENT REPRESENTATIVES

Membership in the Organization of Student Representatives reached a peak during the 1974-75 academic year with 113 of the nation's medical schools represented in the OSR. At its third annual meeting in November, over 125 medical students addressed such issues as health manpower legislation, women in medicine, peer review, and the Goals and Priorities Committee Report to the National Board of Medical Examiners. "Medical Education: Directions for the Next Decade" was the topic of the OSR program session, which focused on current trends in graduate medical education, medical education and its relationship to the nation's health care needs, and innovative programs in curriculum.

The OSR Administrative Board met four times between national meetings to conduct OSR business and to act on behalf of the Organization on all issues being considered by the Executive Council. Administrative Board members also participated in joint meetings with the Administrative Boards of the three councils, and this format provided a means for more effective participation in Association activity.

Medical school accreditation and the involvement of students in the accreditation process has been an issue of continuing concern to the OSR during the past year. At the April Administrative Board meeting, a special working group was formed to develop a pamphlet for distribution to student representatives of schools scheduled for an accreditation site visit. The accreditation pamphlet will inform students about the process by which medical schools are accredited and the nature of LCME site visits and will provide guidelines on mechanisms which can be implemented at each individual school to ensure appropriate student input to the process.

Items of interest to medical students and accounts of OSR activities were reported to all U.S. medical students this year via the new *OSR-AAMC Bulletin Board*, a quarterly publication in poster format which is inserted in the *Student Affairs Reporter*.

National Policy

The resignation of an American President under unpopular circumstances normally could be expected to lead to a change in the policies of the previous Administration. But this expected change did not occur; the Association continued to pursue national policies on issues affecting the medical schools and teaching hospitals in an atmosphere of resistance to federal expenditures for social purposes. Legislative deadlocks, presidential vetoes, and administrative withholding or rescission of duly appropriated funds were evident once again this year. The inability of the Congress to enact badly needed legislation was compounded by the issuance of complex regulations placing new constraints on the medical schools and teaching hospitals.

The Association welcomed an assertion by the new President that he planned an early attempt at having national health insurance legislation passed by Congress. But even as the Association prepared to cooperate in this effort, word was disseminated that plans were changed. The mood of the new administration was to be one of fiscal conservatism—no new programs. In establishing this new mood, the veto became a principal tool. Among its many victims was an extension of health services and nurse training programs. Ironically, a new health services and nurse training bill, again vetoed in 1975, became law on the first override of a veto by the new Congress.

The Association has been concerned with the new health resources and planning act which combined and extended existing authorities for the comprehensive health planning, regional medical, and Hill-Burton construction programs. Since passage of the bill, a committee appointed by the Executive Council has advised the Association on its interaction with officials of the Department of Health, Education, and Welfare in interpreting and planning the implementation of the new law.

One of the chief concerns of the Association and its member schools and hospitals was the lack of legislative authority for health manpower programs. The Association's position was based on two reports, one in 1973 and the other in 1974, prepared by the Committee on the Financing of Medical Education and put into proposed form by the Committee on Health Manpower. With no bill passed by the Congress by the time of the

Association's annual meeting and with the outlook uncertain, an Association task force was appointed to re-examine pending legislative proposals and the Association's position. Taking note of the stalemate between the House and Senate over their separate versions of health manpower legislation, the task force developed a set of recommendations which was adopted by the Executive Council in time for early consideration by the new Congress convening in January.

The Association conveyed its proposal to the Senate in a written statement and to the House in testimony. At the request of Congressional staff members, this proposal was drafted into a bill (S. 992 and H.R. 3279). The Association urged continuation of capitation support with incentives for undertaking expansion of enrollment and programs in primary care and underserved areas, strengthening the National Health Service Corps to meet geographical distribution problems, and residency limitations to meet specialty distribution and foreign medical graduate problems. The House passed its bill, with a mandatory payback or service provision and with no residency limitations, in July. But, as the Association's year ended, the Senate had yet to hold hearings.

In February 1975, the Administration's budget for the fiscal year beginning July 1 was sent to Congress. Reflecting previous Presidential suggestions, the budget proposed no new health programs and officially deferred Administration interest in a national health insurance program. Under the budget, traditional training grants and fellowships would be abolished as well as general research support grants. The budget proposed rescinding a number of appropriations already made by Congress in the health field. Further cutbacks were proposed in financial reimbursement for hospitals under Medicare and Medicaid.

The Association responded to these proposals in a number of ways. It again joined efforts by the Coalition for Health Funding and other interested groups in urging Congress to overrule the rescission and withholding of funds already voted by both the House and Senate for needed health programs. The Coalition was successful in its attempts to have Congress defeat the Administration's proposed deferrals and rescissions

and in its efforts to obtain increased funding for federal health programs.

A new factor in the budget-making process was the creation of Budget Committees in both the House and Senate to help Congress set over-all spending goals and ceilings. The Association provided testimony to both Budget Committees on what it felt priorities should be in spending for health research and education.

The Association filed an *amicus curiae* brief on behalf of the Department of Health, Education, and Welfare 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 argued that research protocols should remain confidential for a period of at least one year after the awarding of the grant, when the project did not involve research on human subjects. Following the court's decision against DHEW, the House Subcommittee on Health and the Environment expressed concern over the effect of the ruling and asked the President's

Biomedical Research Panel to examine the issue and recommend what legislation might be needed.

Final rules for the administration and regulation of Title IX affirmative action requirements of the 1972 Education Amendments and the non-discriminatory admission requirements of the Public Health Service Act were issued during the year. The Association reviewed the rules when they were originally published in proposed form and offered comments to DHEW for their improvement.

For the formulation of national policy statements the Association draws upon experiences gained in similar situations abroad. For this purpose, efforts are being made to monitor the development of national health services in Great Britain and Sweden and particularly their impact on medical education. In view of the rapid developments on the Canadian health scene and the many similarities and differences of approach between our country and Canada, the evolution of the health insurance concept in Canada and its consequences for health services organization and health professions education is of special interest.

Working with Other Organizations

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

During this past year, the CCME completed the revisions to its report, "Physician Manpower and Distribution: The Primary Care Physician," which was subsequently adopted by the parent organizations. A second report, "Physician Manpower and Distribution: The Role of the Foreign Medical Graduate" was prepared and critiqued at the CCME-sponsored National Invitational Conference on the Foreign Medical Graduate. This report has been modified and forwarded for approval. A third major issue has been addressed by the CCME/LCGME Committee on Financing Medical Education and the Impact on National Health Insurance. The report of this committee has been received by the AAMC and extensive comments have been provided. As a major policy organ of the five parent organizations, the CCME has been asked to testify before Congress on the specialty distribution of physicians and on the immigration of foreign medical graduates.

The Liaison Committee on Medical Education continues to serve as the nationally recognized accrediting agency for programs of undergraduate medical education. During the 1974-75 academic year the LCME conducted 37 accreditation surveys as well as consulting by 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 P.L. 92-541. Under Subchapter I of the law, Pilot Program for Assistance in the Establishment of New State Medical Schools, the LCME reviewed three applications and issued one letter of reasonable assurance. Under Subchapter II, Grants to Affiliated Medical Schools, the LCME reviewed thirteen medical school applications involving enrollment

increases and issued letters of reasonable assurance to all thirteen schools.

The Liaison Committee on Graduate Medical Education assumed its official functions in the spring of 1975. The LCGME is now reviewing and ratifying the actions of each of the twenty-three Residency Review Committees. The Committee has the final authority to approve, disapprove, or place on probation residency programs in all recognized disciplines. Training program directors and hospital administrators now receive their formal notice of the status of their residency programs from the LCGME. As the Liaison Committee has evolved its procedures, there have been progressive modifications of the policies under which the Residency Review Committees operate. These modifications include standardizing of procedures for placing programs on probation or withdrawing approval and, most importantly, the development of an appeals mechanism so that adverse decisions may be appealed to a review panel mutually agreed upon by both the appellant and the LCGME. The LCGME is now in the process of rewriting the general essentials for graduate medical education and is also studying how subspecialty training programs in the various disciplines can be reviewed and approved.

The establishment of a Liaison Committee on Continuing Medical Education was approved this year by the CCME and the five parent organizations. Representatives to the LCCME have been appointed and it is expected that the LCCME will soon begin to function parallel to the other liaison committees.

The AAMC continues to collaborate with the American Medical Association and the American Hospital Association on issues of common interest. Particular subjects for joint discussion this year were regulations imposing ceilings on hospital routine service cost reimbursement under Medicare and the availability of institutional malpractice insurance.

The Coalition for Health Funding, which the Association helped form six years ago, now has fifty non-profit health related associations in its membership. A Coalition document analyzing the Administration's proposed health budget for fiscal year 1976 and making recommendations for in-

creased funding is widely used by Congress and the press.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with members representing both the educational and professional associations of eleven different health professions. The Federation's activities during the past year were mainly concerned with the renewal of health manpower legislation. The Association staff has also worked closely with the staff of the American Association of Dental Schools on matters of mutual concern.

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

The Association has maintained its close working relationship with the staff of the Institute of Medicine of the National Academy of Sciences. The Association is represented on the Advisory Committee of the IOM study of foreign medical graduates, which is part of the Institute's

Congressionally-mandated study of the reimbursement of physicians in the teaching setting.

The National Council for International Health collaborated this year with the Coordinating Council on Medical Education to sponsor the National Invitational Conference on Foreign Medical Graduates. The AAMC is one of nine sponsoring organizations of the NCIH.

The Association, through its membership on the Board of Trustees of the Educational Council for Foreign Medical Graduates, was instrumental in encouraging the merger of the ECFMG with the Council on Foreign Medical Graduates to form the Educational Commission for Foreign Medical Graduates. The reconstituted ECFMG certifies the credentials of foreign medical graduates desiring to enter programs of graduate medical education in the United States.

The staff of the Association has maintained close working relationships with other organizations representing higher education at the university level, including the American Council on Education, the Association of American Universities, and the National Association of State Universities and Land-Grant Colleges.

Education

There is a growing emphasis in U.S. medical schools on providing education to both undergraduate and graduate students in settings other than the conventional teaching hospital. One impetus behind this movement is to provide educational experiences which will influence students to consider careers in the primary care specialties and to interest them in settling in geographic areas where there are shortages of physicians and health services. In June 1975, 67 schools responded to a request for brief descriptions of their programs for improving geographic distribution. Most schools reported evolving opportunities for students to spend a portion of their clinical education in sites remote from the medical school. More often than not these experiences are required rather than elective. Almost all schools indicated confidence that these experiences would influence students' career choices, but they felt that it was too early to measure the outcome.

Because remote site education is highly variable from school to school, there is a need to describe the types of programs which are evolving and to identify the opportunities and problems these new ventures are providing. Representatives from seven schools which have had considerable experience with alternate site education were brought together in June to discuss the approaches for assessment of the state of development of alternate site educational programs throughout the country. For descriptive purposes, three categories of alternate site education were defined — basic science in an alternative institution remote from the clinical educational facilities, complete clinical science education in an alternate institution or consortium of institutions remote from basic science educational facilities, and partial clinical science education in an alternate site or sites of varying sizes and complexity. It is planned to investigate the problems related to faculty development, curriculum development and evaluation, student evaluation, and administration and financing in each of these categories. The Liaison Committee on Medical Education is working toward the establishment of guidelines for clinical science schools remote from the basic science facility of the responsible, degree-granting institution.

Frequently, alternate site education is developed to provide access to ambulatory clinical teaching

settings. The need for improvement and enlargement of ambulatory teaching settings in the medical schools is widely recognized. Through a contract with the Health Resources Administration, the Association is embarking upon a study directed toward assisting the schools to accomplish this. The staff is also working with six schools to evolve a plan for utilizing health maintenance organizations as undergraduate educational settings.

An educational innovation which was particularly stimulated by the Comprehensive Health Manpower Training Act of 1971 was the three-year curriculum. Through a contract with the Division of Physician Education of the Bureau of Health Manpower, the Association is studying the impact of the three-year curriculum on both students and the schools. The results of this study will be available in late 1976.

The Association has received support from the W. K. Kellogg Foundation and the Commonwealth Fund for a four-year program to improve faculty skills in education. A voluntary, confidential self-assessment of faculty members' teaching responsibilities and effectiveness is being developed and will be pilot tested during the 1975-76 academic year. Workshops, self-instructional units, consultation services, and assistance to university-based faculty development programs are planned.

The AAMC/AADS (American Association of Dental Schools) Educational Materials Clearinghouse Project, funded by a contract with the National Library of Medicine, became operational with the establishment of AVLINE in May 1975. In the four-month test of this new computerized information storage and retrieval system for audiovisual educational materials in the health sciences, 48 selected institutions will have access through the National Library of Medicine's bibliographic retrieval system, MEDLINE, to 261 abstracts in the field of neuroscience. The projected target date for national availability of AVLINE is late 1975, at which time the data base is expected to be approximately 900 abstracts. There will be continued identification and review for inclusion in AVLINE of multimedia educational materials which are particularly recommended by the faculty. Identifying problems in the distribution of the multimedia materials contained in the AVLINE data base will be an ongoing responsibility of the

Association. This collaborative project with the National Library of Medicine will increasingly be engaged in developing a program to achieve wide sharing of computer-based educational materials. A joint meeting of the principal developers of computer-based educational materials was held with staff from the NLM Lister Hill National Center for Biomedical Communications and the Association in February to begin planning this thrust.

The Medical College Admissions Assessment Program, with the advice and guidance of the Committee on Admissions Assessment, moved toward revising the Medical College Admissions Test. During the year the decision was made to defer the implementation of the revised cognitive battery from the spring of 1976 until the spring of 1977. This will allow more time for communication with the users prior to its introduction and facilitate the research necessary for validation of the new instruments. The contract provides for the construction of tests in the areas of analytic reading, quantitative skills, biology, chemistry, and physics. Additionally, items to assess problem-solving skills will be included. Expected to be a strong feature of the new test is extensive content validation of the new components. Carefully selected evaluators in medical education and practice have identified the important content and skill prerequisites, both for the study and practice of medicine. Workshops explaining the new program were presented at the 1975 regional meetings of the Group on Student Affairs and the National Association of Advisors for the Health Professions. "An Introduction to MCAAP Cognitive Tests," the first in a series of publications related to the Medical College Admissions Assessment Program, was issued in March 1975.

During 1975 support for the Longitudinal Study of the Class of 1960 was received from the National Center for Health Services Research. Staff development is now underway, but planning for surveying the 2,516 physicians in the cohort began in February. The survey will seek information on the types and organization of their practices, their practice settings, the characteristics of their patients, their utilization of personnel and technological resources, their interprofessional relationships, and their involvement in continuing education. This information will be correlated with extensive data obtained from these physicians during their years in medical school. The Longitudinal Study data base is a national research resource maintained by the AAMC and available to qualified investigators. Policies are maintained by the Association to protect the individual privacy of physicians in the study's data base.

A task force appointed by the Chairman of the Association to make recommendations on the

proposals of the Goals and Priorities Committee of the National Board of Medical Examiners reported in the fall of 1974. The task force's recommendations were thoroughly studied by all three Councils, the Organization of Student Representatives, and the Group on Medical Education. At its June meeting, the Executive Council reached a consensus on a report to be presented to the Assembly at the annual meeting. The input from the Association's constituency in developing this consensus has been extremely broad. Acceptance of the proposal that there should be developed a qualifying exam at the interface between undergraduate and graduate education is a major decision which will significantly affect access to graduate medical education in this country.

Increasingly, the quality and characteristics of graduate medical education are being recognized by public policy-makers as major determinants of the types and quality of physicians entering practice. The Association supports upgrading the quality of graduate medical education programs through greater institutional responsibility by academic medical centers for graduate medical education and through improved accreditation standards and mechanisms. The Association has also supported proposals to regulate the number of residency positions to be made available in the various specialties.

The Group on Medical Education expanded its membership to include individuals designated by their deans as having particular responsibilities in the areas of continuing education and graduate education at their institutions. It is anticipated that the addition of individuals with these responsibilities to the Group on Medical Education will expand the Association's activities in both continuing and graduate education. The Liaison Committee on Continuing Medical Education has been approved by all five sponsoring parent organizations as the third Liaison Committee with accreditation responsibilities and authority under the Coordinating Council on Medical Education. The establishment of this Committee is timely, as more and more state legislatures are considering requiring continuing medical education for maintenance of licensure.

Made possible by continued support from the National Fund for Medical Education, the *AAMC Education News* completed its second year of publication in June 1975. Since its establishment its circulation has grown from 33,000 to nearly 40,000 individuals.

P.L. 480 Public Health Overseas Fellowship Programs served to make medical educators aware of both the value of an international setting for conveying principles of community health and the need which students have for some background

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preparation prior to undertaking an international elective. It was recognized by the AAMC, however, that only a few U.S. medical schools have the faculty or financial resources to provide students with an international elective and that budgetary constraints are forcing reassessment of those educational offerings presently available. It was considered advantageous to combine recent advances in educational methodology with available expertise in international health to produce self-instructional educational packages which could be used individually by all interested medical students. In 1974 and early 1975 the purpose and the content of an Introductory Course in International Health using self-instructional materials was outlined. The course will emphasize comparative and transcultural aspects of health and diseases. A total of approximately 40 instructional units are anticipated. Each unit will require one to one and

one-half hours of reading time for the average student.

Five or more demonstration units should be completed in time for the 1975 annual meeting, while the entire program is expected to be ready for testing at a five-school sample by May 1976. Following expected program revisions, the material will be submitted for review to the National Library of Medicine and hopefully released in early 1977 for use either as an individual student elective or as a source of supplementary materials to be used by faculty in conjunction with community health offerings. It is anticipated that these materials can be made available at a nominal charge to cover only the cost of printing and distribution. A contract from the John E. Fogarty International Center of the National Institutes of Health provides the necessary funding for the development of the course.

Biomedical Research

The AAMC has continued to be very actively involved in many aspects of biomedical research policy. The past year has been marked by increased efforts to reassess national biomedical research policies. National commissions have been created for review of policies concerning research training (Commission on Human Resources of the National Academy of Sciences), ethics (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research) and research funding and management (President's Biomedical Research Panel).

Members of the Association have assisted the Commission on Human Resources of the National Academy of Sciences in a feasibility study of national needs for research personnel. The Association anticipates that it will continue to work with this Commission, particularly in gathering the data needed to permit a continuing assessment of national research personnel needs.

Association staff and members played a key role in the development of federal regulations for the protection of human subjects. With the appointment of members of the National Commission it became increasingly apparent that effective testimony would be needed to demonstrate the value to society of biomedical and behavioral research in human subjects. Anti-abortion groups whose primary interest lay in the prohibition of fetal research were actively lobbying for an absolute ban on fetal research. The Council of Academic Societies took a leadership role in organizing and coordinating testimony before the Commission. By all accounts this testimony was highly coordinated and very effective in presenting the benefits to be gained from permitting limited fetal research under controlled conditions. The culmination of this effort was the promulgation by the Commission and the DHEW Secretary of reasonable guidelines, similar to previous regulations supported by the Association but extending moral and ethical considerations in a laudable way. The Association staff is continuing its active dialogue with members of the Commission as they turn their attention to the protection of prisoners, children, and other special groups of human research subjects.

The President's Biomedical Research Panel was created by act of Congress in mid-1974 and appointed in February 1975. At their spring meetings the Council of Academic Societies and Council of Deans formulated opinions and presented testimony to members of the Panel. Both Councils emphasized their concern for the instability of research funding, the need for support of research training programs and basic biomedical and behavioral research, and the need for increased participation of the research community in the planning of future biomedical and behavioral research initiatives. Responding to this dialogue, the President's Panel set up a number of study groups of scientists whose responsibility is to examine the state of the art of 12 clusters of research endeavor and to advise the Panel what steps should be taken to conduct research more effectively in each area. A study of the impact of federal research funding on the academic medical center has now been undertaken by a consortium of the AAMC, the American Council on Education, and the Rand Corporation.

In the renewal of the National Heart, Blood Vessel, Lung and Blood Disease Act, the AAMC took an active part in bringing together suggestions from the research community. This activity led to improved legislation renewing authority for these activities for the next two years. The Association in concert with the Coalition for Health Funding took an active part in testimony on the appropriations for the National Institutes of Health and obtained an average nine percent increase in federal funding for research in these areas.

The Association was very active in dealing with problems relating to the effect of the Freedom of Information Act on research grant protocols. The Association believes that protection of the intellectual property rights of scientists, the protection of the public, and the advancement of science require that research grant protocols be held confidential during the grant review and award process. Recent court decisions interpreting the Freedom of Information Act have generated many problems for the research community which the AAMC is seeking to remedy.

Health Care

Through a variety of programs, the Association assists academic medical centers in developing improved health care systems. These activities are conducted with the advice of the Health Services Advisory Committee.

With a view toward focusing on the issues related to the education of physicians for careers in primary care, the AAMC in the past year convened a national Institute and organized six regional workshops on primary care. Attended by over 450 individuals, including 50 medical school deans and 200 department chairmen, the Institute focused on such issues as the organization of model systems for primary care practice and education, education of new health practitioners, primary health care teams and interdisciplinary education, and graduate physician training in primary care. The regional workshops provided forums for sharing information and ideas and enabled participants to examine regional primary care issues in greater depth. The full text of the Institute presentations plus a summary and analysis of the workshop activities will be published as a supplement to the *Journal of Medical Education*.

This year the Association initiated a new program to assist selected academic medical centers in developing model hospital-based ambulatory care delivery systems. The program is aimed at key institutional decision-makers who are seriously interested in the provision at their institutions of one-class, comprehensive, accessible primary care services and in improving educational opportunities in primary care for graduate and undergraduate students. Funded by the Health Resources Administration, the program calls for conducting two small but intensive four-day workshops and providing ongoing technical assistance for up to ten institutions. A project advisory committee representing consumers and constituents who have successfully restructured ambulatory care services in their institutions is being established.

The 21-month project to develop model curricula for physician training in health

maintenance organizations, initiated over a year ago, is continuing. Six academic medical centers in cooperation with their affiliated HMOs are preparing new, model curricula designed to introduce medical students and residents to the HMO setting and instruct them in the basic concepts of this form of health care delivery. At the initiative of project participants, a symposium on the design, evaluation, and cost of these curricula is being prepared for presentation at the 1975 annual meeting. A final report will be issued in February 1976.

The development of techniques for quality of care measurement and related educational efforts are gaining increasing importance as Professional Standards Review Organizations are established nationally. In this connection, the Association recently sponsored a two-day exploratory conference on quality assurance initiatives in medical education. Attended by 25 individuals including constituent faculty members and DHEW representatives, the conference assessed the state of the art on quality assurance teaching methods and explored initiatives the Association might undertake in this area. As a result of the conference, the Association is presently negotiating with DHEW for the support of a three-year project to develop experimental educational programs at ten institutions.

The need for improved health care systems and medical school involvement in their development is not unique for the United States. The problem is shared at different levels of sophistication in almost all countries. With the view of developing mutually beneficial program activities, the Association conducted a comparative study on the existence and significance of community health training programs in medical schools in developing countries (Colombia, Ethiopia, Thailand, and Turkey). The assessment led to the conclusions that there is a general awareness of the need for extending existing health services, particularly in rural areas, and that in response to these needs medical faculties are beginning to adjust their educational programs.

Faculty

In September 1974, the Association, in keeping with its mission to provide programs and services in response to identified needs of its constituents, created a Division of Faculty Development within the Department of Academic Affairs. The Division's overall goal is to contribute to raising the quality and efficiency of medical school educational programs, primarily by helping faculty members enhance their effectiveness as teachers. The first major activity has been the beginning design of a self-assessment program that will enable faculty members to undertake a confidential self-assessment of their teaching responsibilities and effectiveness. In addition, the Division has taken over responsibility for the annual *AAMC Curriculum Directory* and the *AAMC Education News*, which is sent to all full-time medical school faculty members.

The programs of this new Division are being supported by a four-year grant from the W. K. Kellogg Foundation and a three-year grant from the Commonwealth Fund. Additional funds for specific activities are being provided by a contract with the Bureau of Health Manpower. The National Fund for Medical Education has provided primary support for the *AAMC Education News*.

The Association's Faculty Roster project, financed under a contract with the Bureau of Health Manpower, 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.

The Faculty Roster contains information on 39,891 active faculty members, and 72 percent of these records have been either added or updated since January 1974. In cooperation with administrative personnel at the medical schools, substantial progress has been made in improving the completeness and accuracy of the data base. Reports to the schools have reflected this improvement.

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.

Recently published reports developed from the faculty roster data base include *Mobility Characteristics of U.S. Medical School Faculty, A Preliminary Analysis of Differential Characteristics Between High and Low Mobile Medical School Faculty, Institutional Variables Related to High Faculty Attrition, Medical School Characteristics Associated with Faculty Participation in Federal Programs, and Postdoctoral Versus Non-Postdoctorals: Career Performance Differentials Within Academic Medicine*. A comprehensive descriptive report on medical school faculty is currently in preparation. Plans are being developed for study of current faculty manpower utilization and projected needs.

Results from the 1974-75 Medical School Faculty Salary Survey were released in March by the Association. Conducted annually, this survey continues to provide medical school administrators, department chairmen, and others with a valuable tool for reviewing faculty salary trends. The number of individuals included in this survey has been increasing—from 27,830 during the 1973-74 survey to 31,311 full-time positions reported during the 1974-75 survey. The total number of full-time faculty members is approximately 35,000.

Students are

An emphasis on modifying the characteristics of the health care system by influencing the career selection of both undergraduate and graduate medical students is now dominating the attention of academic medicine. At the 1974 annual meeting, the Group on Student Affairs presented a program on the topic, "Medical Student Selection: Its Role in Geographic and Specialty Distribution."

The number of students seeking to enter medical school may now be decreasing, but applications continue to exceed by a large quantity the increasing number of places available. As admissions committees attempt to select from these candidates those whose interests and backgrounds suggest that they may ultimately choose careers in primary care and settle in areas where practicing physicians are scarce, there is a great desire for reliable, predictive criteria which will assist in selecting students with these characteristics. Some schools are correlating the backgrounds of their previously admitted students with their ultimate career selections after they have graduated from medical school. It is not surprising that most of these studies have demonstrated that students coming from particular social or cultural backgrounds are more likely to return to similar settings. AAMC studies to improve correlations of biographical information with predictions of career choice are a part of the research and development program for the Medical College Admissions Assessment Program.

Solid and reliable information regarding personality characteristics and ultimate career choice is also desired by the schools. The Committee on Admissions Assessment this year established a working group to develop a proposal on non-cognitive assessment. The goal is to identify non-cognitive characteristics in American medical school applicants to assist medical school admissions committees in making selection decisions. While there is no expectation that it will be possible to define the characteristics which will predict that a medical student will ultimately enter primary care or settle in a geographic scarcity area, it is expected that the addition of noncognitive information beyond that commonly achieved through interviews and letters of recommendation will be of value in the selection process.

Representatives from the U.S. Public Health Service and the National Health Service Corps attend-

ed all four regional meetings of the Group on Student Affairs and discussed with student affairs representatives and advisers the opportunities available in the National Health Service Corps for students wishing to participate in resolving problems related to geographic maldistribution.

During the application cycle for admission to the 1975 entering class, 41,688 applicants filed 358,815 applications. The growth in entering class size during the past five years appears to be continuing and the goal of 15,000 entering students by 1976, which was set by the Association in 1970, will be easily achieved. Total medical student enrollments in U.S. schools were at an all-time high during 1974-75, with over 53,500 in attendance as compared with less than 51,000 the previous year. An AAMC retention study scheduled for publication in the October 1975 *Journal of Medical Education* indicates that approximately 95 percent of these enrollees can be expected eventually to receive the M.D. degree.

Through the Early Decision Program and American Medical College Application Service, the students and the schools were assisted in the application process. Fifty-five schools participated in the Early Decision Program, and 984 students were admitted. It is estimated that because each of these students filed only a single application, approximately 6,500 applications did not have to be processed by the medical schools. Eighty-six schools are now participating in AMCAS. The variety of data processing services available to these schools continues to increase. The applicant record-keeping assistance, which is provided to the schools, is proving to be of significant benefit. The assistance of the Division of Student Services staff is available to schools utilizing AMCAS. This year, nine schools requested consultative assistance.

The experimental trial of an admissions matching plan involving the medical schools in California and Michigan resulted in a decision not to pursue nationwide matching for admission to medical school. This decision was reached by the Administrative Board of the Council of Deans because the experimental trial demonstrated that the matching plan would provide few benefits to either the students or the schools. The rigidity in scheduling which would be required appeared to make successful broad implementation unlikely.

In response to the increasing number of U.S. students seeking medical education abroad and the pressures exerted by these students for admission at different levels in the educational continuum, the Association is bringing together data on the problems and issues created by this situation. Of particular concern to the Association is the Fifth Pathway program which is supposed to facilitate the return of students from the Universidad Autonoma de Guadalajara to the United States. The concern is that this program leaves these students with neither a medical degree nor ECFMG certification and thus prevents them from being licensed in a number of states. Because of pressure from individual state legislatures on U.S. medical schools to initiate Fifth Pathway programs, there is great need for close consultation between the Association and the medical schools to avoid undesirable situations and particularly to avoid mandatory requirements for programmatic changes in medical education which may affect the quality of educational programs.

The Coordinated Transfer Application System for U.S. citizens studying in foreign medical schools was continued. In 1974, through COTRANS, 1,126 students were certified by the AAMC as eligible to take Part I of the NBME examination. Of these, 262 students were accepted as transfers into U.S. medical schools. Use of COTRANS by students continues to increase. However, the medical schools are limited in their ability to take these students in transfer because the rapid expansion of entering classes during the past five years is placing major strains on available clinical facilities.

During this year the National Intern and Resident Matching Program violation monitoring system, instituted through the energies of the Organization of Student Representatives, was first tested. Although over half the schools have monitoring committees, students have been reluctant to report that they have been approached to make commitments to graduate programs prior to the match. Only a handful of reports were received and only two students were willing to be identified. A survey conducted in the spring of 1975 indicated that violations of the matching plan were much more common than the complaints processed through the monitoring system would indicate.

In order to continue the effort to increase opportunities for careers in medicine for minority students, the Simulated Minority Admissions Exercise, first developed in 1974, was offered to groups of admissions officers, advisers, and medical school admissions committees. Workshops were conducted for nine groups. The publication, *Minority Opportunities in U.S. Medical Schools*, which was last issued in 1971, was updated. The Medical

Minority Applicant Registry was prepared and circulated to all U.S. medical schools to assist the schools in identifying minority candidates seeking admission to medical school. Because of increasing concern over the number of lawsuits being filed against medical schools charging reverse discrimination in the selection of minority students, a survey was conducted to determine the characteristics of the suits and their outcome. Most suits have been settled in favor of the school or declared moot. However, it is clear that unless schools can justify their selection of students on the basis of policies not related to race, ethnic origin, or sex, there is a significant risk that suits brought on the charge of discrimination will increase and may be decided in favor of the plaintiffs.

An increasing number of minority students are now proceeding into the graduate phase of their medical education. A study conducted by James L. Curtis, M.D. and published in the *Journal of Medical Education* in June 1975 indicates that a high proportion of minority students are successfully achieving the graduate programs of their choice.

Financial aid for the expanding number of undergraduate medical students is a matter of continuing concern. Perpetuation of federal involvement in providing financial aid to students who otherwise would be denied the opportunity to enter or continue in medical schools was a major emphasis in the Association's interactions with policy-makers. The era of provision of federal grants-in-aid without student obligation is ending. While loans will continue to be available, former scholarship support is being transferred into programs such as the Armed Forces Health Professions Scholarship Program or Public Health Service Scholarships, both of which require service paybacks for awards received. Rising tuitions and the increased cost of living are expected to have a significant impact on students' financial needs. A survey to determine how students are financing their education is now in progress. The results of this survey will assist in anticipating what the financial needs of students will be during the next several years. Data on total resources available to medical schools for student financial aid are being refined. Two confidential reports to schools comparing their resources with national averages and identifying for each school its rank in comparison to other schools were prepared this year. Through the GSA regional meetings, continued assistance was provided in dealing with problems related to the administration of student loan and scholarship programs.

In August 1974 President Ford signed into law the Elementary and Secondary Education Amendments of 1974 which included an amendment entitled the

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"Family Educational Rights and Privacy Act of 1974" sponsored by Senator James L. Buckley. The Buckley Amendment was enacted without legislative hearings and caused considerable consternation among student affairs officers and advisers because of its broad requirement that students be permitted access to all information in their academic files, including letters of recommendation. Interpreting this Act and the DHEW regulations for its implementation and monitoring the debate which surrounded it was an important and time-consuming staff activity. Largely as a result of concern expressed by the academic community, the Buckley Amendment was subsequently modified by the Congress. It now specifies which educational records and individuals are covered by the Act and permits students to waive access to confidential letters of evaluation.

The status of whether interns and residents are employees of hospitals or are students in programs of graduate education became a major issue when, in 1974, the National Labor Relations Act was extended to include non-public health care facilities. Several local housestaff organizations petitioned the National Labor Relations Board for recognition as collective bargaining agents for house officers. The Association filed an *amicus curiae* brief on behalf of its member hospitals with the NLRB in April 1975. The Association's position asserted the educational nature of house officer training and detailed the detrimental impact on the educational programs which would occur if the structure, function, and content of graduate medical education were subject to the adversary process of labor negotiations.

Institutional Development

The Management Advancement Program, now in operation three years, is intended to afford deans and their management teams an opportunity to acquire a working understanding of management principles as they may be applied within the academic medical center. The Management Advancement Program was planned by an AAMC Steering Committee chaired by Ivan L. Bennett, Jr., M.D. The Steering Committee has sought the advice of a number of individual consultants and experts on design of the overall effort.

Phase I, the Executive Development Seminar, is a six-day program held at Endicott House in Dedham, Massachusetts. For deans only, it is an intensive workshop in management technique and theory as they are presently known and understood. It has provided an opportunity for deans to share common problems while acquiring theoretical background knowledge in the general management area. The curriculum of the initial Executive Development Seminar has been developed by faculty from the Alfred P. Sloan School of Management, Massachusetts Institute of Technology.

Building upon the Phase I experience, Phase II, the Institutional Development Seminar, permits the management team from each participating school to work on a problem that they have actually been experiencing within their own medical school setting. Each dean brings five or six people who will be able to work with him as change agents upon their return home. An overview of Phase I content is provided to bring the whole team to a functional working level in applying the management concepts. At least half of the seminar time is spent in individual team sessions working with consultants specifically assigned to each school to assist in dealing with the particular problems which the school has identified for study. Consultants are selected for their expertise in organization development or in the area of planning and control. These consultants represent a number of different academic and professional affiliations.

Experience has demonstrated the demand for opportunities for medical school representatives to participate more than once in learning experiences similar to the seminar setting of Phase II. Underlying the design of the program is the perception that the leadership of the academic medical center and 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. This means involvement not only of the principal manager or executive, but of a whole group of those concerned with the development of the institution and its programs. Finally, the need for follow-up and reinforcement is recognized and accounts for the iterative nature of the program.

To meet this demand, the Phase III format is being developed for institutions who wish to return for a second seminar, whether with the same team to follow-up the same or a different aspect of the problem studied in Phase II or with a new team working toward broadening the base of individuals in the organization who are involved.

With the fifth Phase I, August 1975, 100 deans have participated in the Executive Development Seminars. The follow-up seminars have involved 47 institutions in Phase II and 13 in Phase III. Over 400 individual participants have attended; in addition to the deans, 95 department chairmen, 24 hospital administrators, 19 vice presidents, 4 chancellors, as well as program directors, business officers, and planning coordinators have attended.

Funds for the planning and implementation of the first seminar were awarded by the Carnegie Corporation of New York and the Grant Foundation. A grant from the Robert Wood Johnson Foundation permitted the full implementation of the program for the first two years. A second major grant, also from the Robert Wood Johnson Foundation, will provide program support for an additional three-year period.

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 education 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, the Association has underway a series of descriptive and analytic studies of the

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academic medical center. A Delphi survey to forecast the future of medical education completed the previous year was analyzed and the results published.

Using the experience from this study, planning has proceeded on a second survey to identify problems and issues in the organization, management, and governance of the medical schools and academic medical centers.

The file of documents relating to the governance of the schools from which such matters as the organizational structure and governance process can be examined was expanded. Supplemental data will be gathered for each institution by interview and questionnaire. Two specific areas which have been studied are the process and authority for the appointment of deans and department heads and the composition, selection, and scope of involvement of university and hospital governing boards in medical center affairs.

A study of deans' office organization, staffing, and salaries which will provide comprehensive information from all 116 member medical schools is currently underway. Complementing this, an in-depth study of selected institutions has been undertaken to provide more refined descriptive information about the levels of responsibility borne by institutional officials, groups, committees, or components in the decision-making and implementation process. A study of the critical points of interface between medical schools and teaching hospitals, whether owned or affiliated, with emphasis on the purposes of the relationship and the degree of interdependence among the institutions was initiated. Efforts continued to identify studies of significance to medical center management from the literature and to facilitate the initiation outside the Association of such studies.

The Association also is interested in institutional development abroad, particularly in Latin countries

of the western hemisphere. In collaboration with the Panamerican Federation of Associations of Medical Schools, the Association launched a program aimed at a close collaboration between social security institutions in Latin American countries and their medical schools.

Such a close relationship has been considered desirable both because of the increase of the number of medical students in these countries and the demand for greater breadth in the range and complexity of available health settings for teaching purposes. The first phase of the three phase project dealt with an examination of the existing resources of social security institutions and their availability for educational purposes. The second phase has concentrated on the preparation of workshops at selected Latin American sites in which to analyze difficulties of achieving close collaboration between the social security institutions and medical schools. To this effect, regional workshops have been held in Costa Rica and Mexico City and further workshops are planned in Rio de Janeiro, Lima, and Quito. The third phase is expected to focus more specifically on a realistic basis for collaboration within individual countries and particularly will deal with the problems and issues generated by the introduction of an educational task into a predominantly service organization.

In order to assist better the institutions in meeting the public expectations and legal requirements to assure equal opportunities for women and for minorities, the Association during the year identified more specifically areas within it which had pertinent information. Participation by staff members in a number of conferences has provided a forum for formal and informal exchanges of information on these matters, which have a significant impact on the institutions.

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 May, the Association filed a lawsuit and request for preliminary injunction against DHEW Secretary Weinberger and SSA Commissioner Cardwell seeking to halt implementation of the Section 223 schedule of limits on Medicare reimbursement for routine service costs. The regulations implementing this section of P.L. 92-603 provide that hospitals be grouped on the basis of bed size, per capita income of the area, and geographic location. In taking these steps on behalf of its member teaching hospitals, the Association asserted that the result of the actual implementation of the schedule would be the imposition of an irrational and unfairly discriminatory scheme, which would operate to disallow reasonable costs. The limitations failed to take into consideration the elements required to differentiate effectively between efficient and inefficient institutions. Furthermore, implementation of the new schedule was expected to cause irreparable harm to an excessively large number of teaching hospitals. In the legal brief submitted to the court, the Association noted that hospitals would be forced to reduce or eliminate necessary health services, contrary to the intent of Congress.

Late in June, the Court denied the Association's request for an injunction, thereby allowing the implementation of the regulations. Following that action, the Association requested the Court to reconsider its decision. Following the denial of its motion for reconsideration, the AAMC filed formal notification of appeal. The Association staff has met with representatives of the Social Security Administration Bureau of Health Insurance in an attempt to ameliorate these problems.

The Taft-Hartley Act was amended last year to include within its jurisdiction all non-public health care facilities. Since implementation of the amendments to the Act, numerous house officer associations have petitioned individual teaching hospitals for union recognition. Although such hospitals are covered by the Act, there are questions as to whether interns and residents

should be considered as employees or students excluded from its jurisdiction.

All of these petitions for recognition are currently pending before the National Labor Relations Board. Because of the impact which the Board's decision will have on medical education at all levels, the Executive Council decided that the Association would not be fulfilling its obligation to maintain the standards of medical education unless it asserted the educational nature of intern and resident positions and opposed any actions which would make the structure and function of graduate medical education subject to the adversary process of labor relations. Subsequently, the Association submitted an *amicus curiae* brief to the Board on behalf of its member hospitals. In this brief, the Association argued that interns and residents are students and not employees within the meaning of the Act, that the purposes and policies of the Act would not be effectuated by the assertion of jurisdiction over interns and residents, and that the assertion of such jurisdiction would have a significant detrimental impact upon the structure, function, and content of graduate medical education.

Regulations which result from passage of the 1972 Social Security Amendments (P.L. 92-603) continued to appear throughout the past year. A portion of Section 227 regulations, issued by the Department of Health, Education, and Welfare, will allow teaching hospitals the option of electing cost reimbursement for Medicare patients under certain conditions. The Association filed comments on the proposed regulations which were subsequently issued in final form on August 8, 1975. Remaining parts of Section 227 regulations are being withheld by DHEW pending conclusion of the Institute of Medicine study. The Institute's analysis of medical center organization and financing should provide some clarification which hopefully will produce a set of solutions to a difficult problem. The Association has worked closely with the IOM and has encouraged its member teaching hospitals and medical schools to participate.

Other regulations and administrative changes which appeared during the year include the utilization review regulations, Medicare requirements for institutional planning and budgeting, renal disease regulations, health maintenance organization regulations, elimination of the Medicare nursing

TEACHING HOSPITALS

differential, and an economic index restricting physician fee increases. All of these actions necessitated an AAMC response to their publication and in most instances DHEW implementation followed shortly after the close of the comment period. A descriptive analysis of the institutional impact of each of these was usually distributed, along with copies of the regulations, to each teaching hospital member.

In response to the many concerns expressed over the impact of Medicare regulations on the nation's hospitals, the House Ways and Means Subcommittee on Health scheduled special hearings. Invited Association testimony at these hearings emphasized the mass of litigation which had been generated by Medicare regulations, commenting that these actions reflected a serious problem in the relationship of the health care institutions to the federal agencies.

The National Health Planning and Resources Development Act was signed by President Ford in January 1975. In creating a network of local Health Systems Agencies and Statewide Health Coordinating Councils, the legislation will significantly alter the old Comprehensive Health Planning agency structure. The law mandates a stringent review process for new facilities and services, in addition to requiring periodic reviews. Another provision calls for agency review of federal funds employed for the development of certain federal projects and programs. To provide guidance to the Association during implementation of the planning law, the Executive Council appointed a special task force to review the law and identify the particular elements which may require the Association to respond. An AAMC position paper prepared by the task force on agency review of federal funds was submitted to DHEW staff for consideration during the regulations development process. Further position

papers along with analyses of proposed regulations will be prepared during the forthcoming year.

At the request of the Joint Commission on Accreditation of Hospitals, the AAMC convened a task force to analyze the JCAH Guidelines for Medical Staff Bylaws and the extent to which the Guidelines address the needs of the teaching hospitals. After consideration of the various unique characteristics of a teaching hospital's arrangement with a medical school and other related issues, the Association prepared a list of recommended changes and alterations to the bylaws.

Requests for membership from organizations which have a commitment to medical education but which do not meet the present criteria for COTH membership resulted in the formation of an ad hoc committee to review COTH membership criteria. The ad hoc committee recommended and the Executive Council later approved the establishment of a new AAMC membership category entitled Corresponding membership. This type of membership would be made available to non-profit and/or governmental hospitals which do not meet the COTH membership criteria.

The Association staff conducted two special surveys of the teaching hospitals during the past year. In the first, a survey of hospital governing boards, the Association examined the structure, composition, and requirements for membership on the teaching hospital board. Information was collected on the selection procedures and on recent changes which have taken place in the organization and composition of the board. The other survey was for the purpose of analyzing the extent of state appropriations to university-owned and/or operated hospitals. Data from this instrument was summarized and distributed to those taking part in the project.

Communications

A variety of publications, news releases, news conferences and personal interviews are used by the Association to communicate its views, studies, and reports to its constituents, interested federal representatives, and the general public. The major vehicle used by the Association to inform its constituents is the *President's Weekly Activities Report*. This publication, which is issued 43 times a year and reaches about 9,000 subscribers, reports on AAMC activities and federal activities that have a direct effect on medical education, biomedical research, and health care. In addition to the *Weekly Activities Report*, other newsletters of a more specialized nature are: *AAMC Education News* (sponsored by The National Fund for Medical Education), *The Advisor*, *COTH Report*, *Student Affairs Reporter*, *OSR Bulletin Board*, and *DEMR Report*. Numerous other publications such as directories, reports, papers, studies, proceedings, and archival listings also were produced and distributed by the Association.

The monthly *AAMC Bulletin* was discontinued following the June 1975 issue. The publication was dropped to reduce costs and because of duplication of contents in the *AAMC Bulletin* and the *President's Weekly Activities Report*. It also was felt that *WAR*, because of its more frequent publication, could offer readers more timely information on fast-moving Congressional and government developments and AAMC activities. Individual AAMC members, who in the past had received the *AAMC Bulletin* as part of their membership ser-

VICES, are now receiving the *Weekly Activities Report*.

The *Journal of Medical Education* in fiscal 1974-75 published 1,242 pages of editorial material compared with 1,331 pages the previous year. The regular issues carried two supplements during the year: "Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education" and "Financing Undergraduate Medical Education." One issue contained a special section on primary care. The plenary addresses from the 1974 AAMC annual meeting and the 1974 AAMC Proceedings and Annual Report also were published in the *Journal*. Excluding the supplements, a total of 167 papers (92 regular articles and 75 communications) were published, compared with 154 papers in fiscal 1974. The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine.

The volume of manuscripts submitted to the *Journal* for consideration continued to increase. Papers received in 1974-75 totaled 422, compared with 397 and 359 the previous two years. Of the 422 articles received in 1974-75, 125 were accepted for publication, 203 were rejected, 19 were withdrawn, and 75 were pending as the year ended. Pages of paid advertisements totaled 91 pages during the fiscal year, compared with 83 pages the previous year. As the year ended, the *Journal's* monthly circulation was about 6,500.

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 is a computer-based information source structured and managed by an integrated data base computer software package. The basic organization of the data base is structured around the medical school in that a variable, as described, is present and retrievable for each medical school. The primary sources of data for the Institutional Profile System have been repetitive and ad hoc data collection instruments administered by the AAMC, and other information systems maintained by the Association such as the Student and Faculty Profile Systems.

The primary objective of the Institutional Profile System is to provide a readily accessible repository of valid, reliable data that describes and differentiates the medical educational environment. The accomplishment of this objective will benefit the medical schools, in that repetitious data collections will be reduced.

The Institutional Profile System became operational in the fall of 1974. The system was first presented and demonstrated at the AAMC annual meeting of that year. At that time, the IPS contained some 1,500 variables for each medical school derived from three sources of data. The system has grown, in less than one year, to more than 6,000 variables for each medical school derived from 30 sources of data.

Use of the IPS has grown significantly during the past year. Specific requests from medical schools number 108 with most of these being in the latter half of the year. The system is used heavily within the AAMC to support data requirements. In addition, access to the system via computer terminal at the medical school is planned for implementation during 1976.

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 housestaff stipends, comparative revenue and expense data, and analyses of collective bargaining trends.

For the seventh successive year, the *COTH Survey of House Staff Policy* was published. 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. In addition, the seventh annual survey of teaching hospital executive salaries is in the data collection stage and results will be disseminated in early December.

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.

ASSOCIATION OF AMERICAN NURSING COLLEGES
1975

Treasurer's Report

The audited statements and the audit report for the fiscal year ending June 30, 1975 were carefully examined by representatives of the Association's auditors, Ernst and Ernst; by representatives of the Association's legal counsel, Williams, Myers and Quiggle; by members of the Association Audit Committee; and by Association staff on September 4, 1975. At its meeting in Washington on September 19, 1975 the Executive Council reviewed and accepted the final unqualified audit report. The auditors stated that they did not intend to issue a management letter, since the Association's fiscal and internal control systems were adequate and no recommendations for their improvement were being made.

Total income for the year increased 5.40 percent to \$7,970,535. Operating expenditures totaled \$7,057,954.

Balances in funds restricted by the grantor decreased \$152,117 to \$428,414, while unrestricted funds available for general purposes increased \$940,711 to \$4,030,118—a reserve equal to 57 percent of expenditures during the year. By action of the Executive Council the officers of the Association have been directed to maintain unrestricted reserves of not less than 50 percent and, as a goal, 100 percent of the annual operating budget. Such a goal is a reasonable one and its achievement should be a continuing mandate on the officers of the Association.

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TREASURER'S REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES BALANCE SHEET June 30, 1975

ASSETS

Cash	\$ 104,135
Certificates of Deposit	250,000
U.S. Treasury Bills	4,889,234
Accounts Receivable	704,871
Deposits and Prepaid Items	39,676
Investments in Management Account	814,825
TOTAL ASSETS	<u>\$6,802,741</u>

LIABILITIES AND FUND BALANCES

Liabilities	
Accounts Payable	\$ 494,698
Deferred Income	795,765
Fund Balances	
Funds Restricted for Special Purposes	1,185,304
Funds Restricted for Investment in Plant	296,856
General Funds	4,030,118
TOTAL LIABILITIES & FUND BALANCES	<u>\$6,802,741</u>

OPERATING STATEMENT

Fiscal Year Ended June 30, 1975

SOURCE OF FUNDS

Income	
Dues & Service Fees from Members	\$1,508,822
Grants Restricted by Grantor	544,039
Cost Reimbursement Contracts (Net of Adjustments)	1,684,101
Special Services	3,372,542
Journal of Medical Education	66,774
Other Publications	183,967
Sundry	610,290
TOTAL INCOME	<u>\$7,970,535</u>
Reserve for MCAT Development	231,179
Reserve for Special Minority Programs	19,609
Reserve for Special Legal Contingencies	100,000
Decrease in Restricted Fund Balances	152,117
TOTAL	<u>\$8,473,440</u>

USE OF FUNDS

Operating Expenses	
Salaries & Wages	\$2,917,172
Staff Benefits	521,538
Supplies & Services	2,904,045
Equipment	50,590
Travel	664,609
TOTAL EXPENSES	<u>\$7,057,954</u>
Transfer to Restricted Funds for Special Purposes	474,775
Increase in Unrestricted Funds Balances	940,711
TOTAL	<u>\$8,473,440</u>

AAMC Membership

TYPE	1973-74	1974-75
Institutional.....	105	109
Provisional Institutional.....	10	7
Affiliate.....	17	17
Provisional Affiliate.....	0	0
Graduate Affiliate.....	1	1
Academic Societies.....	56	56
Teaching Hospitals.....	394	396
Individual.....	2,243	2,149
Distinguished Service.....	0	35
Emeritus.....	63	65
Contributing.....	13	9
Sustaining.....	15	17

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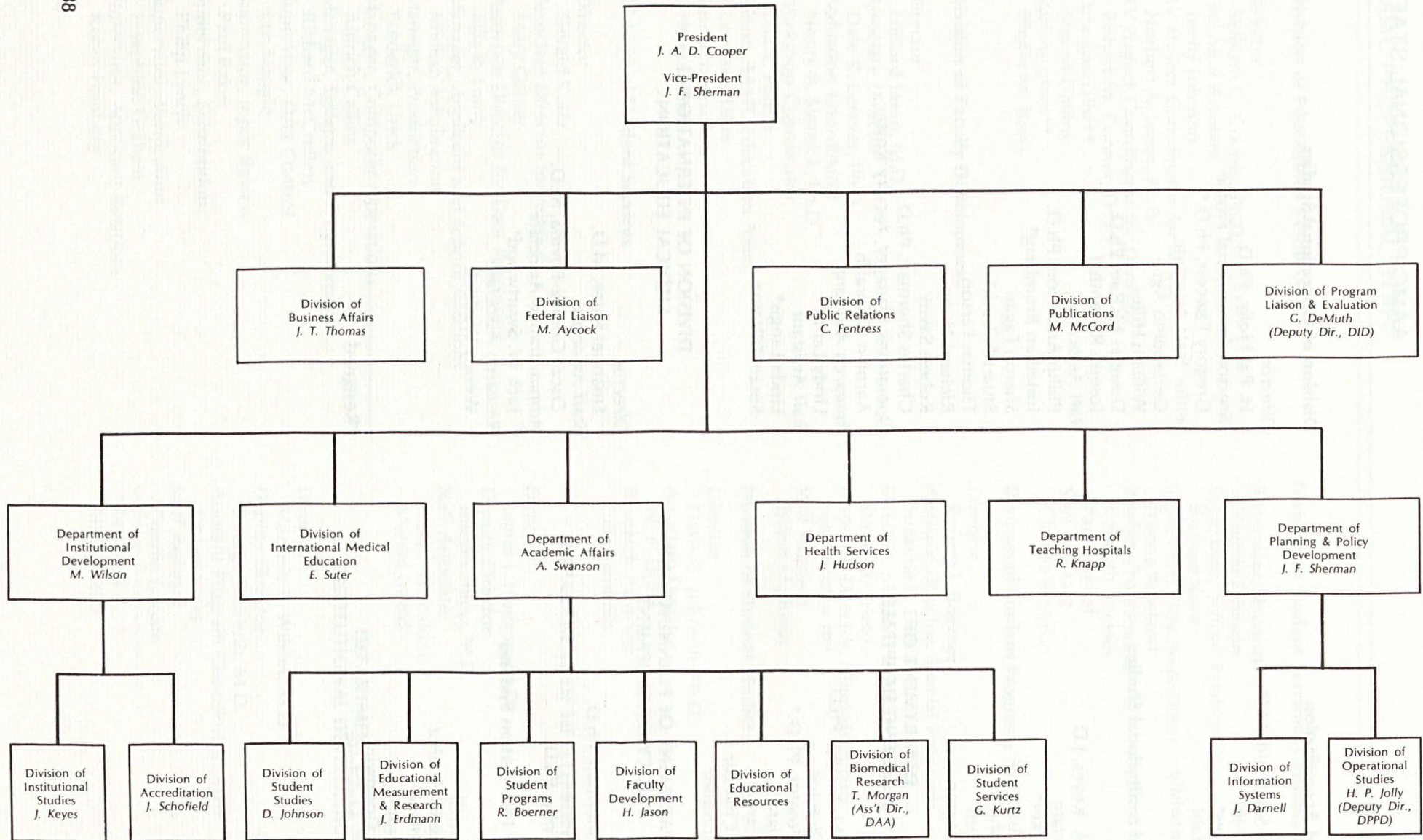
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Jack W. Swartwood*

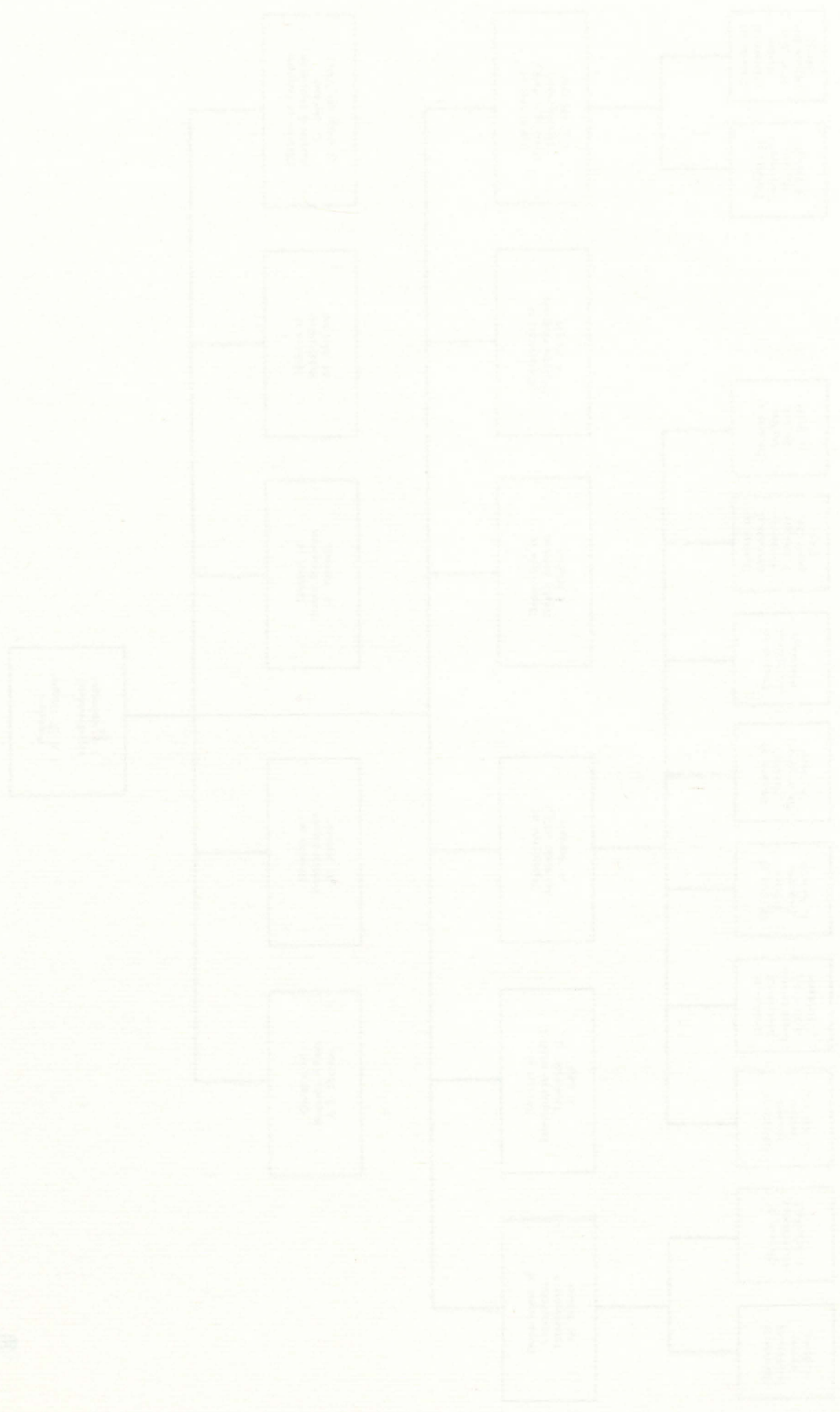
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