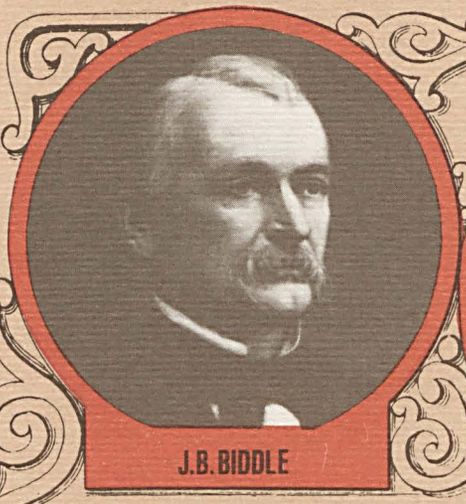
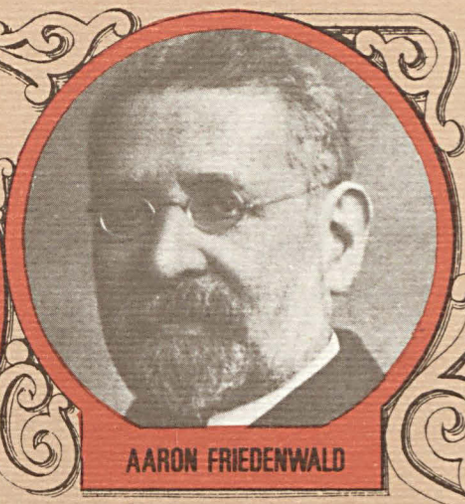
# 1975-1976 ANNUAL REPORT



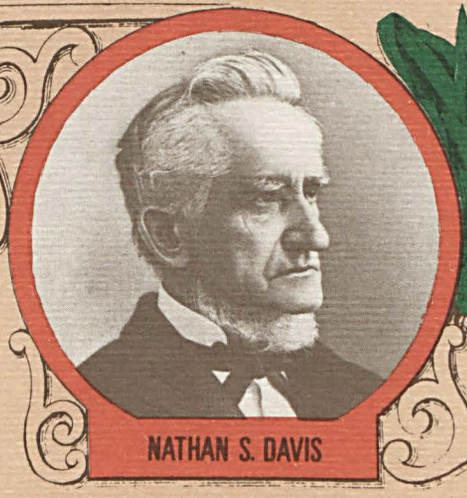
J.B. BIDDLE

J.M. BODINE

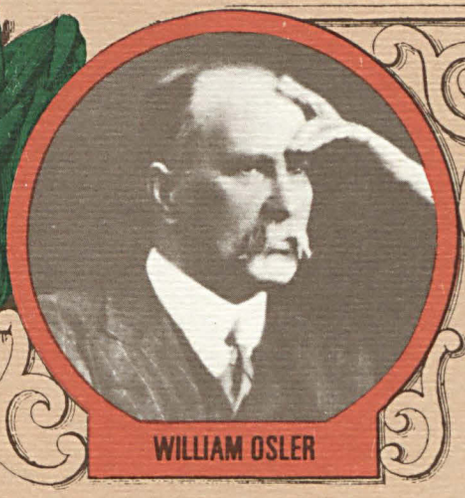


AARON FRIEDENWALD

## The Association of American Medical Colleges 1876-1976



NATHAN S. DAVIS



WILLIAM OSLER

# Executive Council

*Chairman*
Leonard W. Cronkhite, Jr.

*Chairman-Elect*
Ivan L. Bennett, Jr.

*President*
John A. D. Cooper

*Council Representatives:*

**Council of Academic Societies**

Rolla B. Hill, Jr.
A. J. Bollet
Robert G. Petersdorf
Jack W. Cole

**Distinguished Service Member**

Kenneth R. Crispell

**Council of Deans**

John A. Gronvall
J. Robert Buchanan
Christopher C. Fordham, III
Neal L. Gault, Jr.
Julius R. Krevans
William H. Luginbuhl
Clayton Rich
Chandler A. Stetson
Robert L. Van Citters

**Council of Teaching Hospitals**

Charles B. Womer
David D. Thompson
Sidney Lewine
John M. Stagl

**Organization of Student Representatives**

Richard S. Seigle

# Executive Committee

*Chairman*
Leonard W. Cronkhite, Jr.

*Chairman-Elect*
Ivan L. Bennett, Jr.

*President*
John A. D. Cooper

*Chairman, Council of Academic Societies*
Rolla B. Hill, Jr.

*Chairman, Council of Deans*
John A. Gronvall

*Chairman, Council of Teaching Hospitals*
*Secretary-Treasurer*
Charles B. Womer

# 1975-76 ANNUAL REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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Rolla B. Hill, Jr.

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A. J. Bollet

Robert M. Berne
F. Marion Bishop
Carmine D. Clemente
Jack W. Cole
Philip R. Dodge
Daniel X. Freedman
Donald W. King
Thomas K. Oliver, Jr.
Robert G. Petersdorf
Leslie T. Webster

**Council of Deans**

*Chairman*
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*Chairman-Elect*
J. Robert Buchanan

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Andrew D. Hunt
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Clayton Rich
Chandler A. Stetson
Robert L. Van Citters

**Council of Teaching Hospitals**

*Chairman*
Charles B. Womer

*Chairman-Elect*
David D. Thompson

John W. Colloton
David L. Everhart
David A. Gee
Robert M. Heyssel
Baldwin G. Lamson
Sidney Lewine
Stanley R. Nelson
S. David Pomrinse
Malcom Randall
John Reinertsen
John M. Stagl
Robert E. Toomey

*AHA Representative*
William T. Robinson

# President's Message

When the Association was founded 100 years ago, American medical education was at its nadir. The education and training of physicians was still obtained largely in apprenticeships of variable duration and questionable quality. There were few quality standards for medical schools and most of the 101 institutions in operation were proprietary, established more to provide the faculty with a supplement to their inadequate practice income than to advance the art and science of medicine.

However, there were stirrings of change in the air to assist the Association in its goal of raising standards of medical education and eliminating marginal and inadequate schools. Its efforts played a crucial role in setting the stage for the far-reaching reforms that followed Abraham Flexner's 1910 report.

Throughout its existence, the Association has reflected the interests and concerns of the medical schools. Before World War II, the focus was on improving the intrinsic quality of medical education and on bringing the medical schools into the mainstream of university tradition and scholarship. After the war, the medical schools abandoned their introspective mode in the face of pressures originating in the world around them and developed into large, complex academic medical centers. They provided undergraduate, graduate, and continuing medical education for an expanded number of students; trained a rapidly growing number of other health professionals; mounted a biomedical research effort that is one of the wonders of the 20th century; and delivered a substantial amount of hospital and ambulatory care, as well as almost all of the nation's complex tertiary care. In the process, the academic medical centers have become heavily dependent on federal and state funds. This dependence has brought the threat of government interference in their programs and the loss of traditional academic freedoms.

Further expansion of the role of government in our national life and growing Congressional frustration in assuring that quality medical care is available to all citizens at a price we can afford promises that academic medical centers will come under even heavier outside pressures in the future. Unfortunately, the centers provide a convenient target on which to level criticism and to direct legislation and regulation. Given this prospect, they will have to extend their interests and concerns further into the community if they are to protect the fundamental missions and scholarly values of the university.

To meet its new responsibilities to the academic medical centers, the Association has undergone extensive change. In 1968, the governance structure was broadened to encompass the principal components of the academic medical centers. Opportunities have been given to the growing administrative staff of the centers to participate in and contribute to Association activities. The staff has been expanded under a full-time president and chief executive officer and organized into functional departments and divisions to work more effectively with the officers, councils, and the constituency in meeting the new challenges, opportunities, and problems facing the academic medical centers.

Powerful forces are abroad in the land which by advertence or by inadvertence could seriously damage the university as a social institution. These include dissatisfaction with scholarship as an end in itself, more proscriptive legislation, the enormous growth in both size and insensitivity of bureaucracy, the intractable problems of cost and inflation, and a host of others. History has provided ample evidence that the university is an enduring social institution. It has survived the Inquisition, waves of anti-intellectualism, and despots who would impose their wills upon it. But as we begin our second hundred years we are faced by challenges as great as any in history to protect the diversity of our institutions and their right to preserve essential goals and objectives within reasonable societal boundaries.

Are we up to the challenge?

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

# The Councils

## EXECUTIVE COUNCIL

The Executive Council met four times during the year, acting on a wide range of issues affecting the medical schools and teaching hospitals. The Council considered a number of policy questions referred for action by member institutions or by one of the constituent Councils. Except where immediate action was necessary, 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 and executive staff was held in December prior to the first meeting of the new Executive Council. The Retreat participants discussed the major issues which were expected to confront the Association during the coming year, including health manpower, the national health planning law, and methods of financing education in the ambulatory care setting. The Retreat also reviewed several proposed areas of new or expanded staff activity, and offered recommendations on which programs the Association might support and which were worthy of seeking outside support. At the request of the AAMC Assembly, the Retreat discussed frankly the role of the Organization of Student Representatives within the Association, attempting to answer several questions raised by the students at the annual meeting. The Executive Council, at its January meeting, approved the detailed report of the Retreat on these and other major issues.

The progress of health manpower legislation remained a vital interest of the Executive Council throughout the year. After almost two years of operating under authority of a continuing resolution while numerous legislative proposals appeared and disappeared, the Council labored to keep informed of the latest developments and enable the Association to respond effectively on behalf of the schools. The passage and signing of this legislation at the close of the 94th Congress culminated these efforts.

A major policy consideration during the past year was the Association's review and formal response to the Institute of Medicine Social Security Studies. The IOM study, entitled "Medicare-Medicaid Reimbursement Policies," was requested by Congress in response to inequities demonstrated by the Association in the reimbursement of teaching physicians under Section 227 of the 1972 Social Security Amendments. The Administrative Boards and Executive Council formulated a detailed response to the IOM recommendation in this area and in the areas of specialty distribution, financing of primary care training, geographic distribution, and foreign medical graduates.

A second major policy report was reviewed in depth and commented upon by the Executive Council this year. The report of the President's Biomedical Research Panel followed 18 months of deliberations which included meetings with several Association groups and the preparation under contract by the AAMC of a report on the impact of biomedical research funding on academic medical centers. An Association task force, the Administrative Boards, and ultimately the Executive Council scrutinized the Panel's recommendations and, with high praise for the Panel's work, prepared a formal AAMC response. Dr. Franklin D. Murphy, Chairman of the Panel, was asked to discuss the report with the Assembly at the 1976 Annual Meeting.

As a result of concerns raised by several deans, the Executive Council appointed a special Task Force on Student Financing to examine the problems faced by students in paying for their medical education and to recommend solutions which might be effected by the schools, by federal or state agencies, or by the private lending community. Of particular concern was the possibility that highly qualified students from lower income families were bypassing medicine as a career choice because of financial inaccessibility.

A 1969 AAMC task force had made extensive recommendations for better minority student recruitment, admissions, and retention with 1976 set as the target date for achieving certain numerical and qualitative goals. The Executive Council recognized that, despite encouraging signs in previous years, the enunciated goals would not be met. A special Task Force on Minority Student Opportunities in Medicine was charged by the Council with preparing a follow-up report to the 1969 study, identifying why the goals proved unachievable and what the Association and the schools could do to increase the real opportunities available to minority students.

On the recommendation of the Retreat, the Council established a Committee on Governance and Structure to review all requests for organizational change within the representative structure of the Association. The Committee reviewed requests for the establishment of new groups in the areas of minority affairs and continuing medical education and recommended the creation of formal sections within existing groups to provide the desired forum without destroying important interrelationships. Both the Council and the petitioning groups endorsed these recommendations.

A task force charged with assessing the AAMC role in the rapidly expanding field of continuing medical education presented its report to the Executive Council in March. The report defined continuing medical education and reviewed the variety of problems and pressures affecting its application. The task force outlined the Association's role and limitations in continuing education and recommended the appointment of an ad hoc committee to recommend national policies, particularly relating to the functioning of the Liaison Committee on Continuing Medical Education. The Executive Council endorsed this recommendation and a committee was appointed.

As one of the parent organizations of the Coordinating Council on Medical Education, the AAMC is asked to ratify all CCME policy statements. This year three major actions were forwarded for the Executive Council's approval. The Council approved a report on "Physician Manpower and Distribution: The Role of the Foreign Medical Graduate," reiterating its earlier disapproval of a section dealing with Fifth Pathway programs. CCME Recommendations on Financing Graduate Medical Education reflected the considerable input of the Council of Teaching Hospitals and were approved. The Executive Council also approved a CCME-recommended Procedure for Approval of New Specialties under which the Coordinating Council and its parent organizations would have the ultimate responsibility for recognizing a new specialty.

At the request of staff of the Senate Finance Committee and the COTH Administrative Board, the Executive Council commented on draft legislation replacing the current routine hospital service cost limitations with a new cross-classification system for "primary affiliates of accredited medical schools." The Council also authorized the Association's legal counsel to appeal a U. S. District Court decision upholding the classification system currently being applied under DHEW regulations.

The Executive Council authorized the Association's participation in other legal actions where counsel felt that involvement would be advantageous. The AAMC filed an *amicus curiae* brief in the California Supreme Court defending a school's special admission program for disadvantaged students as consistent with the safeguards of the Equal Protection Clause. The Council also authorized the filing of an *amicus curiae* brief, if appropriate, to argue that the National Labor Relations Act pre-empts state labor laws where the NLRB has assumed jurisdiction over the concerned employer. Final determination on filing a brief awaits further development of the case.

The 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. Although the Council has delegated full authority for accreditation decisions to the LCME, the decisions are formally ratified by the Executive Council to assure consistency with all state licensing laws. This year, the Council commented on LCME Guidelines to the Functions and Structure of a Medical School and approved Supplemental Guidelines for Medical Schools with Branch or Multiple Campuses.

Since the establishment of the Organization of Student Representatives in 1971, one OSR representative has sat with vote on the Executive Council. At the recommendation of the Council of Deans, the Executive Council approved and recommended to the Assembly a Bylaws change which would provide two OSR votes. This amendment was based on changes in the OSR rules and regulations ensuring better continuity of representation.

The Council's Executive Committee met prior to each Executive Council meeting and by conference call on numerous occasions throughout the year. The Committee met with HEW Under Secretary Marjorie Lynch in January to discuss the process of Departmental regulation-writing. The full Council and four Administrative Boards met with HEW Assistant Secretary for Health Theodore Cooper in June to discuss the rising cost of health care and its impact on other federal health programs.

At the recommendation of the Executive Committee, the Council appointed a Finance Committee charged with recommending how the Association might finance the programs and activities deemed appropriate by the Council while operating within the established reserve policy. The Committee was asked to review all sources of Association income.

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 1977.

## COUNCIL OF DEANS

In addition to its annual business meeting, the Council of Deans sponsored three programs at the Association's 1975 Annual Meeting in Washington, D.C. The first program, jointly sponsored with the Council of Teaching Hospitals, considered recent experiences of schools and hospitals with various organizational arrangements designed to enhance coordination of their teaching and patient care responsibilities. The focus of the featured presentation and panel discussion was reflected in the program title, "Consortia: New Patterns for Inter-Institutional Coordination." The second program featured a discussion with the Veterans Administration Chief Medical Director on recent developments affecting the relationships of VA hospitals to medical schools. Accompanied by his chief staff officers, the medical director addressed such topics as the recently-enacted physicians pay bill, regionalization of the VA system, VA appropriations, and the VA's participation in the establishment of new state medical schools. Finally, the COD joined with the Council of Academic Societies and the Council of Teaching Hospitals in sponsoring a program entitled "Maximum Disclosure: Individual Rights and Institutional Needs." Two speakers addressed different aspects of the issues involved, one emphasizing the societal interest in submitting information and issues to open review and critique, one emphasizing the personal and institutional costs of disclosing matters where privacy, candor, or proprietary interests were at stake.

The November business meeting was devoted to passing on a series of matters for Assembly action, consideration of the selection procedures for student representatives to the AAMC, election of officers, and discussion of both the Council and Association program for the coming year. In its discussions of the program ahead, the Council reviewed the status of a survey on governance issues and the planning for its Spring 1976 Retreat. Tentative decisions of the program committee suggested that this meeting would be related to governance issues at the medical school/university and medical school/teaching hospital interfaces.

The Administrative Board met quarterly to carry on the business of the Council. It deliberated on all Executive Council agenda items of significance to the deans and devoted substantial attention to the accrediting responsibilities of the AAMC. Two interpretive documents of the Liaison Committee on Medical Education, "Guidelines to the Functions and Structure of a Medical School" and "Supplemental Guidelines for Schools with Branch or Multiple Campuses," were critically examined by the Board in joint session with the CAS Administrative Board and with representatives of the Liaison Committee and staff. The Board approved a pamphlet prepared by the Organization of Student Representatives to assist students in institutions being surveyed for accreditation to participate effectively in that process.

At the suggestion of a Council member, the Board devoted particular attention to the unavailability of student financial assistance. The serious shortfall in available funds as compared to demonstrated need and its possible effect on the socioeconomic mix of applicants stimulated the Board to suggest the appointment of an Executive Council Task Force to recommend some specific solutions.

The Council's spring meeting, held this year in Clearwater, Florida, continued the tradition of an annual three-day retreat devoted to a series of issues of significance to deans. A substantial portion of the program, "The Academic Medical Center: Present and Prospective Challenges," was devoted to major governance issues surrounding medical school/teaching hospital relationships. The Council received a sociologist's conception of images of leadership, and a composite view of the relative influence of participants in the resolution of issues at the medical school/teaching hospital interface, as perceived by deans, department chairmen, and hospital directors. Small groups of the Council addressed themselves to a series of discussion questions, sharing prior institutional and personal experiences. Two morning sessions were devoted to a discussion of five important issues facing academic medicine: problems in student financial assistance; review and response to the IOM Social Security Studies; effect of federal research programs on academic medical centers; availability of adequate numbers of high quality residency programs; and the role of accreditation in medical education.

## COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies held one national meeting during the year. In addition to the annual business meeting, the CAS joined the COD and COTH in sponsoring a half-day program on the impact of provisions of the Freedom of Information Act, the Privacy Act, and other "sunshine laws" on academic institutions. 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. New programs

were initiated by the CAS to improve communications between its member societies, AAMC staff, other AAMC councils, and the federal government.

A major focus of the CAS this year was improving communications with its 59 members societies, which represent over 100,000 individuals. Establishing an effective communications network has been difficult, primarily because of the diversity of the societies' interests, the annual rotation of society officers, and the infeasibility of sending all newsletters and memoranda to all of the individual society members.

The Association continued to publish a CAS *Annual Directory,* which first appeared in 1973. This *Directory* contains a capsule summary of AAMC programs, a brief orientation to the AAMC governance and organizational structure, and a listing of the officers and official representatives of each member society.

To strengthen the communications effort, the Association has begun publishing a quarterly newsletter entitled *CAS Brief.* This newsletter is designed to permit easy reproduction and insertion by member societies into their own journals or newsletters. Items in the *Brief* are written to inform the membership of major public policy issues which face the biomedical research and education community. Eight member societies now recirculate the *CAS Brief* to almost 7,000 individuals.

In another move to improve communications, the president of each CAS society was invited to meet with AAMC staff and the CAS chairman to discuss how more effective and continuous relationships could be established between the member societies and the central office. A significant number of societies have now designated one of their representatives to be particularly responsible for communicating with the AAMC staff and with the officers and members of their society.

Also during the year, the CAS participated in an AAMC-sponsored workshop on improving scientific input to the Food and Drug Administration's decision-making. The objectives of the workshop were to consider the possible effects of several proposals on the academic community and to discuss with members of the Council of Academic Societies possible Association actions. Ramifications of the changes proposed and the function of the FDA were discussed with representatives of the agency.

The CAS Administrative Board carefully scrutinized the activities of the Liaison Committee on Medical Education, paying particular attention to the drafting of "Guidelines to the Functions and Structure of a Medical School." These Guidelines, which elaborate on the basic accreditation policy of the LCME, will be redrafted to accommodate Administrative Board comments. In addition, members of the CAS Administrative Board played a leading role in the preparation of an Association response to the report of the President's Biomedical Research Panel.

## COUNCIL OF TEACHING HOSPITALS

During the year, the COTH Administrative Board held quarterly meetings to develop the programs, interests, and policies of teaching hospitals and to consider and act on all matters brought before the Association's Executive Council. Preceding each Board meeting, evening sessions were held to provide seminar discussions on specific issues.

At the January meeting, Mr. Jay Constantine and two other members of the Senate Finance Committee staff outlined the development of the Medicare-Medicaid Administrative and Reimbursement Reform Act. The Board evaluated suggested concepts and proposed provisions of the bill. Among Board concerns were the removal of housestaff and other types of expenditures from routine operating costs, recognition of the impact of case mix on hospital costs, the classification system to be used for hospitals, and the identification and composition of a specific teaching hospital group for reimbursement limitations. These concerns were communicated to the staff of the Senate Finance Committee through correspondence and additional informal meetings. Following introduction of the bill, the Board re-evaluated its content, expressing concern over a provision to establish a separate cost control category for "the primary affiliate of accredited medical schools." The Board developed this and other concerns with the bill into the Association's testimony, which was presented before the Subcommittee on Health of the Senate Finance Committee in July.

At the March meeting of the Board, three faculty members from the Management Advancement Program presented plans for a pilot program to be held for approximately twenty-five teaching hospital executives. This program was conducted in late June in West Palm Beach, Florida. The future of this particular phase of the management program is under review by the MAP Steering Committee and the COTH Administrative Board.

In June, a joint session of the CAS, COD, and COTH Boards was held to discuss cost containment and other major health issues with Dr. Theodore Cooper, DHEW Assistant Secretary for Health. The September meeting provided an opportunity to explore potential research and experimentation in outpatient reimbursement and cost determination

with Dr. Clifton Gaus, Director, Division of Health Insurance Studies, Social Security Administration.

The COTH Board was particularly active this year in working with the Executive Council in reviewing the Institute of Medicine Social Security Studies Final Report entitled, "Medicare-Medicaid Reimbursement Policies." These efforts resulted in an AAMC position statement on the report which was presented before the Health Subcommittee of the House Ways and Means Committee in August. The Board also reviewed and made recommendations on a wide variety of other issues including outpatient department deficits, financing education in the ambulatory setting, malpractice insurance in university-owned hospitals, Medicare routine service costs, and the President's Biomedical Research Panel Report.

## ORGANIZATION OF STUDENT REPRESENTATIVES

Membership in the Organization of Student Representatives continued at a high level during the 1975-76 academic year with 113 of the nation's medical schools represented. At its fifth annual meeting in November, 86 schools sent over 100 students. The opening session of the OSR Annual Meeting identified topics for later discussion through the technique of group dynamics, which afforded each OSR member the opportunity to raise individual interests and concerns. The major issues which surfaced through this process were health manpower legislation, the status of housestaff, curriculum and evaluation, and the structure and function of the OSR. The OSR jointly sponsored a program with the Group on Student Affairs entitled, "Medical Student Stress: What Have We Wrought?" Various presentors discussed stress factors for students from the admission process through residency training, concluding with an assessment of the impact the OSR and GSA might have in alleviating some of the problems. A highlight of the program was a film from the University of Southern California in which two medical students discussed the stressful aspects of their educational experiences.

The OSR Administrative Board met four times during the year to conduct business and to act on behalf of the Organization on all matters being considered by the Council of Deans and the Executive Council. In addition to being represented at the COD and Executive Council meetings, OSR Administrative Board members participated in the joint meetings of all the administrative boards. This format provided the OSR a means to interact with members of the Administrative Boards of the Council of Academic Societies and the Council of Teaching Hospitals as well.

The OSR has continued to pursue issues related to housestaff education, asking the Association to take positive steps to enhance the educational aspects of graduate medical education. An OSR task force has been asked by the Council of Deans to explore ways in which the AAMC might make graduate training more meaningful.

The long-anticipated accreditation pamphlet has been disseminated to all OSR members and will be made available to students at each medical school prior to each accreditation visit. The pamphlet was designed to enhance student input to the process of accrediting medical schools.

The OSR has continued to press for action on factors affecting student stress in medical education, and has been involved in AAMC activities related to the particular concerns of women in medicine. OSR carried on discussion of these and other issues at its four regional meetings held in conjunction with the GSA and reported its activities to all medical students via the *OSR-AAMC Bulletin Board*—a quarterly publication in poster format inserted in the *Student Affairs Reporter*.

# National Policy

After a full year as President, Gerald Ford's imprint upon the presidency became more apparent. Though initially there were indications that the new Administration would be more responsive to the nation's health needs, government-by-veto continued into 1976 and the Association found itself better able to work toward its goals with the Congress than with the Administration. That situation provided several major successes, among them the overrides of Presidential vetoes of the Health Services and Nurses Training Act, the 1976 Labor-HEW Appropriation, and the 1977 Labor-HEW Appropriation.

Two of the major issues confronting the Association during the past year were health manpower and health appropriations. After several years of consideration, both Houses of Congress passed health manpower bills. The Association worked closely with congressional staff members, testified before committees, and at the request of Senator Kennedy drafted its own bill for consideration. Of particular concern to the Association were provisions on capitation support; the distribution of residency positions among primary and non-primary care specialties; student assistance; National Health Service Corps Scholarships; and the status of graduates of foreign medical schools. The Association, through questionnaires and other contacts, sought to reflect accurately the consensus of its membership on the major issues. Prior to the conference that was called to resolve the differences between the House and Senate versions of the bill, the Association sent a detailed position paper to the conferees outlining the recommendations of the Association and addressing in depth both the conditions for capitation and the student assistance provisions. During the conference the AAMC provided additional input to the conferees and the Committee staffs. In late September the conference report was approved by both Houses and sent to the President. While the Association was not totally satisfied with the final legislation, the conference had eliminated most of the objectionable provisions of the bill. After polling the reaction of the deans to the final bill, the Association urged the President to sign it. President Ford signed the bill, expressing some of the reservations which the Association had expressed to him, thus concluding the tedious renewal of the legislation which had expired over two years earlier.

Another manpower issue of particular concern to the Association centered on financial support for the private medical schools of the District of Columbia—Georgetown and George Washington. Placing Congress and particularly its Committees on the District of Columbia *in loco parentis* to these schools, the AAMC strongly supported the extension of the District of Columbia Medical and Dental Manpower Act of 1970. A one-year extension was approved by Congress and signed by President Ford in June.

As in past years, much of the Association's attention focused on health appropriations. The Administration's budget request for fiscal year 1976 proposed no new health programs and cut back funding in several areas in the health field. Congress substantially increased appropriations but the President vetoed the bill in January on the grounds that it was inflationary. The Association worked with the Coalition for Health Funding, which successfully urged Congress to override the President's veto.

For the first time in recent memory, Congress passed an appropriation bill prior to the start of the fiscal year for which it was intended. The timeliness of the fiscal year 1977 bill was aided by the three-month shift in the start of the federal fiscal year—from July 1 to October 1. The President's budget once again had proposed substantial decreases in health funding from the 1976 appropriated level. Again, the Association joined with the Coalition for Health Funding to urge Congress to increase support for health programs, particularly in the vital area of research training. Congress ultimately agreed to an increase of 260 million dollars over the previous appropriation, exceeding the President's budget by over a billion dollars in the health area. Although a controversial anti-abortion amendment threatened to tie up the bill in conference, it was reported in time to avoid the possibility of a pocket veto. Despite the President's veto within days of the Congressional adjournment, both the House and the Senate easily overrode the veto.

In addition to the issues of health manpower and appropriations, the Association was concerned

with many other activities of the federal government. One of the first events of significance last year was the issuance of final administrative regulations for sections of the Public Health Service Act barring discrimination on account of sex. The NIH implemented new regulations for the protection of human subjects in July and the AAMC continued throughout the year to assist the Commission for the Protection of Human Subjects in its studies and hearings. In June, HEW issued final regulations on privacy rights and educational records, implementing the Buckley Amendment. Regulations issued for the Privacy Act had considerable potential impact on the continuation of important biomedical research supported by NIH contracts at member schools and hospitals. The Association carefully monitored these and other regulations and proposed rule-makings having possible implications for the schools and teaching hospitals.

In April the final report of the President's Biomedical Research Panel was released, following fifteen months of Congressionally-mandated deliberations. The Panel had addressed itself particularly to the organization and management of NIH/ADAMHA, and also made extensive inquiries into the effect of biomedical research funding on the academic institutions which perform most of the nation's biomedical research. The Association participated in studies commissioned by the President's Panel, and, after publication of the Report, constituted a special Task Force to develop a critical evaluation of that document. The Task Force concluded that the Report and its appendices were a remarkably thorough and a persuasive exposition of the strengths and weaknesses of the nation's biomedical research enterprise. The AAMC endorsed the general conclusions of the Report which emphasized the necessity for continued support of a sizeable, high quality, and broad biomedical and behavioral research effort. However, the Association proposed alternate recommendations to several of the Panel's specific proposals.

With the expiration of a previous exemption, students receiving Armed Forces Health Professions Scholarships and Public Health Service Scholarships became subject to income taxation on their tuition stipend and their stipend for books and educational expenses. The AAMC urged members of both the Senate Finance Committee and House Ways and Means Committee to provide quick relief for students being supported under these programs. A provision to extend the exemption from taxation for 1976 and, for those students receiving scholarships in 1976 a further exemption until 1979, was included in the Tax Reform Act, which passed this fall.

Authority also expired in June for the National Heart and Lung Institute. A continuing resolution maintained funding, but at a reduced rate. In April, authority was extended through fiscal years 1976 and 1977, and the Institute's name was changed to the National Heart, Lung and Blood Institute. Throughout the hearings on these programs, as well as on the Labor-HEW appropriations bills, the Association consistently and strongly advocated generous support for research training programs, particularly in the area of institutional awards.

The Association has long been concerned with the Freedom of Information Act and the related Federal Advisory Committee Act as they affect NIH/NIMH peer review of research grant applications. As early as 1973 when the Children's Defense Fund of the Washington Research Project, Inc., brought suit to compel DHEW to release research grant proposals, the AAMC has attempted to protect the confidentiality of the grant award process. In the past year the President's Biomedical Research Panel, NIH Director Donald Fredrickson, HEW Undersecretary Marjorie Lynch, and others have brought similar concerns to the attention of the Congress. After several months of hearings and debates, Congress passed the Government in the Sunshine Act. Under the new law all agency meetings must be open to the public unless one of ten exemptions applies. As a consequence of efforts by the AAMC and others, the House-Senate conferees noted the special problem of NIH and stated that the peer review system must be protected. The conference report stated that the exemptions that allow a meeting to be closed because, if opened, it would be an invasion of privacy or would significantly frustrate the implementation of a proposed agency action, should provide such protection.

At the request of the staff of the Health Subcommittee of the Senate Finance Committee, the Association has assisted in the drafting of the Medicare-Medicaid Administrative and Reimbursement Reform legislation. This bill substantially modified Medicare and Medicaid in the areas of administration, provider reimbursement, practitioner reimbursement, and long-term care. Without endorsing or opposing this bill, the AAMC has offered several constructive recommendations designed to assure that the bill accurately reflects the complexity of contemporary medical education and the provision of services by the teaching hospitals. Further Congressional action on Medicare and Medicaid reform is expected early in the next Congress.

In hearings held in March on the Clinical Laboratory Improvement Act of 1976, the AAMC advised Congress of the possible unintended harm to biomedical research which could result by including clinical research laboratories in the coverage of the bill. As a result of Association efforts, specific exemptions were provided in the House bill for physicians performing their own laboratory work and for research laboratories. However, the Congress failed to complete action on the clinical laboratory bills before adjourning, and this issue is expected to resurface next year.

The Association continues to be deeply interested in the quality of health programs in the Veterans Administration. In this regard the Association worked for an increase in the pay of Veterans Administration physicians and dentists to equal the pay of their colleagues in the armed services and Public Health Service. In October 1975, such an increase was approved. The Association also testified in favor of slightly increased appropriations for the health programs of the VA.

The Association has also noted the difficulty of recruiting individuals to positions of leadership in the National Institutes of Health. This crisis has been caused by the erosion of staff salaries at NIH in relation to salaries in the private sector. The Association urged a restoration of salary comparability or near comparability with the private sector for the directors and senior staff of the several institutes of NIH. The House Subcommittee reported a bill which was expected to pass easily, but in the midst of the usual election-year denials of salary increases the bill died in the full Committee.

Throughout the past year the AAMC has been an active participant in events of national importance outside the legislative arena. In March the National Labor Relations Board refused to extend the jurisdiction of the National Labor Relations Act to unions representing interns, residents, and clinical fellows. By a four-to-one ruling, the Board held that housestaff are primarily engaged in graduate education programs and are not employees within the meaning of the National Labor Relations Act. The AAMC had filed an *amicus curiae* brief with the Board in April 1975, asking that they decline jurisdiction because of the involvement of housestaff in graduate medical education and the potential consequences of collective bargaining on the education process. The Association had joined with several involved members of the Council of Teaching Hospitals in presenting oral arguments on these points before the NLRB.

In May of 1975, the Association filed suit in U.S. District Court to enjoin the implementation of regulations setting ceilings on Medicare reimbursement of routine hospital service costs. Following the denial of AAMC motions for an injunction and for reconsideration, the Association appealed the case to the U.S. Court of Appeals for the District of Columbia Circuit. A hearing on the appeal was held in September and a decision is pending.

The Association also filed an *amicus curiae* brief last March in the California Supreme Court in the case of *Bakke* v. *Regents of the University of California*. In this action, a white male applicant to the University of California Davis School of Medicine claimed that the special admissions program for disadvantaged applicants violated his constitutional rights by discriminating against him on the basis of race. The Association's brief cautioned the Court about the undesirability of having the judiciary make individual determinations of admission to educational programs. Although the Association recognized the legitimate interest of the Court in guaranteeing rights granted by the Constitution, the brief argued that schools should be permitted to tailor their policies to meet perceived educational and societal needs. In September, the California Supreme Court ruled that the medical school's practice of setting aside first-year places for minorities is unconstitutional. The University of California has announced its intention of petitioning for United States Supreme Court review.

Pervading every debate and every issue with which the AAMC has been involved this past year is the steadily rising cost of health care. The price paid for health care in the United States has become a national problem of serious proportions. While aware that the major responsibility to control costs lies with the practicing medical profession and the public, the Association acknowledges that the academic medical sector must also help contain costs. In meetings of groups within the Association, with third-party payers, and with Assistant Secretary for Health Theodore Cooper, the Association has participated in the search for solutions to this problem.

# 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 the past year the CCME completed the revisions of its report, "Physician Manpower and Distribution: The Role of the Foreign Medical Graduate," and actively worked on a policy statement on the specialty and geographic distribution of physicians. The CCME appointed a joint committee with the Liaison Committee on Graduate Medical Education to advise on the opportunities of women in medicine. It was felt that the substantial increase in the enrollment of women in medicine will increasingly affect the residency programs and that there is a need to consider better accommodations to part-time residencies. The report of the joint CCME/LCGME Committee on the financing of graduate medical education was completed and revised by the CCME. Other areas receiving attention are the role of telecommunications and satellite communications in health services and health professions education and the development of a standard order of procedure for the approval of new specialties in medicine.

The Liaison Committee on Medical Education continues to serve as the nationally recognized accrediting agency for 117 programs of undergraduate medical education in the United States and for the medical schools in Canada.

The accreditation process provides for the medical schools a periodic, external review of assistance to their own efforts in maintaining the quality of their education programs. Outside survey teams are able to focus on the areas of concern which are apparent, recommend other areas requiring increased attention, and indicate areas of strength as well as weakness. In the recent period of major enrollment expansion, the LCME has pointed out to certain schools that the limitations of their resources preclude expanding the enrollment without endangering the quality of the educational program. In yet other cases it has encouraged schools to make more extensive use of their resources to expand their enrollments. During the decade of the sixties particularly, the LCME encouraged and assisted in the development of new medical schools; on the other hand, it has cautioned against the admission of students before an adequate and competent faculty is recruited, or before the curriculum is sufficiently planned and developed and resources gathered for its implementation.

The LCME is recognized officially in the federal sector by the Office of Education as the organization responsible for accreditation of undergraduate medical education programs. In the private sector, the LCME was recognized first by the National Commission for Accreditation and now by the Council on Postsecondary Accreditation, a successor agency resulting from a merger with the Federation of Regional Accrediting Commissions of Higher Education.

During the 1975-76 academic year, the LCME conducted 37 accreditation surveys in addition to a number of consultation visits to universities contemplating the development of a medical school. The list of accredited schools is now found also in the AAMC *Directory of American Medical Education,* which first appeared in 1952 and is published annually.

During the past year, the LCME issued Letters of Reasonable Assurance for future accreditation for two new programs in medical education, and granted provisional accreditation to three new medical schools. The attention of the LCME focused on developing guidelines for the policy statement, "Functions and Structure of a Medical School." Also, a task force of the Committee composed supplemental guidelines for medical schools with branch campuses. Both of these documents are in their final stages of revision and will be released shortly.

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 accredit, disaccredit, 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.

A manual has been prepared by the LCGME to provide common policies for the structure and function of residency review committees. The manual, which became effective as of July 1, is a first step toward improving review and approval procedures. Previously, the residency review committees for the 23 specialties for which programs are accredited by the LCGME carried out their functions under individually developed procedures. The new manual, which will be modified as experience demonstrates the need, sets forth standardized policies relating to the review process. The manual does not invade the responsibilities of the residency review committees in the area of setting standards and developing criteria for judging whether programs have met these standards.

In November of the past year the Liaison Committee on Continuing Medical Education began organizational meetings. The major accomplishments were the writing and adoption of the LCCME bylaws, the development of priorities for establishing an accreditation system for continuing medical education, and the adoption of principles of financing the accreditation mechanism. The exact timing for assuming accrediting functions by the LCCME has not yet been set.

The AAMC has continued to collaborate with the American Medical Association and the American Hospital Association on issues of common interest. Joint discussions were held concerning the AAMC's leadership role in asserting the educational purposes of internships and residencies, litigation over the imposition of hospital routine service cost ceilings, and the activities of the other Associations in the malpractice area.

The Coalition for Health Funding, which the Association helped form seven years ago, now has 43 non-profit health related associations in its membership. A Coalition document analyzing the Administration's proposed health budget for fiscal year 1977 and making recommendations for increased 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 as a member of the Board of Trustees continues its active interest in the programs of the Educational Commission for Foreign Medical Graduates. Of the two major programs of the Commission, the sponsorship of the Exchange Visitor Program is of particular importance to the member institutions of the AAMC. Close collaboration between the Association and the ECFMG will become necessary to assure smooth functioning of this program and to provide foreign trainees who are admitted to the United States an appropriate educational experience of high quality.

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. This year the AAMC worked cooperatively with these three organizations as well as others in the higher education area to respond to Uniform Guidelines on Employee Selection Procedures issued by the Equal Employment Opportunity Coordinating Council. Other federal regulations broadly affecting higher education, such as those pertaining to affirmative action and the handicapped, were also the subject of cooperative efforts. The AAMC participates on an Inter-association Task Force on Equal Employment Opportunity staffed by the ACE.

# Education

The uncertainty of federal support and other financial constraints during the recent past have placed increased importance on achieving economies in many aspects of the medical education process. The Association has undertaken through its staff and member organizations a wide variety of activities to enhance the efficiency as well as the effectiveness of the educational programs. In general, these efforts have been attempts at greater coordination of information and resource sharing.

The Group on Medical Education continues to be an increasingly valuable focus for efforts to enhance information and resource sharing. At the national level, a Technical Resource Panel has made suggestions for a pilot study on information exchange to be initiated by the AAMC. Most of the regional groups have also begun specific projects in resource and information sharing, e.g., materials sharing in the West, techniques for off-campus clinical evaluation in the South, curricular innovations in the Central, and methods for instructional evaluation by students in the Northeast. The GME has also been expanding its program offerings at both regional and national meetings to accommodate its expanded responsibilities to representatives from the areas of graduate and continuing education. The GME-sponsored Research in Medical Education Conference has expanded its format to respond to more varied demands for research information exchange through the introduction of a poster session format and the enlargement of its symposium format.

A task force of the Executive Council reaffirmed the importance of continuing medical education and the necessary leadership of the medical schools in this area. To assist the medical schools in this task, the AAMC has appointed an Ad Hoc Committee on Continuing Medical Education. The committee has identified the need to initiate research and development programs in order to establish a firmer scholastic foundation for this important and costly academic function.

The AAMC Collaborative Program for Developing a National Resource for Educating Health Professionals, funded by a contract with the National Library of Medicine, contains three programs, two of which relate to AVLINE and Computer-Based Educational Materials. AVLINE is a computerized information storage and retrieval system for educational materials in the health sciences. All subscribers to the National Library of Medicine's bibliographic retrieval system, MEDLINE, may access AVLINE, which now contains some 1600 abstracts chiefly in the areas of neuroscience, cardiovascular, musculoskeletal and reproductive systems. The materials cited in AVLINE are selected by means of a systematic appraisal process involving content experts and educational technologists. A wide range of subject areas and levels of learning experiences in the health sciences will eventually be included. A study is being made of the usefulness of the information system and the responsiveness of the various materials distribution services. A research study has been done on the reliability of the instruments used to appraise materials. Based on these data the appraisal instruments have been revised. Further research is intended to identify those qualities of a material most likely to predict learner success.

The task in the area of computer-based educational materials in the health sciences is the facilitation of the sharing of these programs. The major developers of such materials are participating with AAMC in the development of criteria for the appraisal of computer-based educational programs and in conducting pilot appraisal runs applying these criteria to selected programs. These appraisals are expected to yield critical abstracts of reviewed programs to be made available to potential users and to be incorporated in a comprehensive information system. In addition, the Association is collaborating with the Lister Hill National Center for Biomedical Communications in the design of research and development programs for the Learning Resource Center.

Although international clerkships are providing a valuable type of community health offering, the Association has recognized that budgetary constraints are forcing a curtailment of many international activities. It has sought to combine available expertise in international health with advances in educational methodologies by developing self-instructional education materials which can be used by medical students who have an interest in the international perspectives of health and health care. The production of international health

materials is a two-year undertaking expected to result in approximately 35 course units. Each unit will require 60-90 minutes of study time for the average student. The course should be ready for pilot testing in the fall of 1976. Following the needed program revisions, the material will be submitted for quality review and released in early 1977 for use either as an individual student elective or as a source of supplementary material 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, National Institutes of Health provides the necessary funding for the development of the course.

The final report of the Study of Three-year Curricula in U.S. Medical Schools will be available by the summer of 1977. Over 5,000 individuals representing faculty, students, administration, and clinical program directors responded to a questionnaire regarding the impact of the three-year curriculum on institutional operation. The results of curriculum analysis, student progress data, student career choice patterns, and program conversion information will be analyzed with the questionnaire data. The description of the process of reconversion to the four-year program by a substantial number of institutions that conducted three-year programs will be included in the study.

The Biochemistry Special Achievement Test has increasingly become a tool for program evaluation. Originally the test was used for purposes of advanced placement, but schools have begun using the test for a widening variety of purposes in the recent past. It is now also administered as a diagnostic tool to identify areas of student weakness, to test self-paced students on an individual basis, and as a final examination.

The New Medical College Admission Test will be first administered to students in the Spring 1977. The examination is presented in four sections: Science Knowledge, Science Problems, Skills Analysis: Reading, and Skills Analysis: Quantitative. The science tests cover biology, chemistry, and physics, and reflect common entry requirements for medical school. They will measure understanding of important concepts and principles and their application. The skills test in reading includes content generally familiar to applicants, and assesses those reading and intellectual skills needed in medical school. It may also serve to identify students for whom further diagnosis of reading difficulty might be needed. The quantitative test requires solution of quantitative problems in the sciences and mathematics, especially involving logical reasoning and data interpretation and utilization. The skills examinations are designed to assess cognitive skills, rather than mastery of any particular body of knowledge. A new test manual has been prepared to provide detailed information about test content. It was designed as a comprehensive guide to assist students as they prepare to take the New MCAT.

The New MCAT will provide six scores to be reported to students and designated medical schools. Science knowledge and problems questions will be combined and reported for each disciplinary area, giving scores in biology, chemistry, and physics. Problems will be combined to yield one science problems score. Skills analysis tests will yield one score each for reading and quantitative. Workshops explaining the new program have been held at the 1976 regional meetings of the Group on Student Affairs and the National Association of Advisors for the Health Professions.

Following the recommendations of the Committee on Admissions Assessment, a proposal was prepared for the development of techniques for more formal assessment of the non-cognitive qualities of medical school applicants. Seven personal qualities were identified on which more extensive and reliable information is sought by admissions officers. Two research companies and two university-based research groups were identified as potential collaborators for providing instruments aimed at measuring these qualities: compassion, coping capabilities, decision-making, interprofessional relations, realistic self-appraisal, sensitivity in interpersonal relations, and staying power. The proposal was submitted to a number of funding agencies.

The 1976 follow-up of physicians who participated in the Longitudinal Study of Medical Students of the Class of 1960 is continuing under a two-year grant awarded to the AAMC by the National Center for Health Services Research (NCHSR). Approximately 2500 study physicians, graduates of 28 selected study schools, were sent a questionnaire in mid-May. The inquiry addresses both long term career development and current professional activities of these physicians. Information from this latest up-date will be correlated with information obtained from the group as medical students to examine the relationships of education, training, and medical practice.

# Biomedical Research

The focus of much AAMC activity during the past year was the President's Biomedical Research Panel, which was charged by Congress in 1974 with assessing the status of the nation's biomedical research effort. In 1975 the Council of Deans and the Council of Academic Societies brought to the attention of the President's Biomedical Research Panel the need for a study of the impact of biomedical research funding on academic institutions. The Panel, in response, contracted with a consortium led by the American Council on Education and including the Rand Corporation and the AAMC to study the effect of Federal programs and policies on institutions of higher education in general and academic medical centers in particular. Members of the Executive Council and Administrative Boards advised AAMC staff throughout the course of this study. Results of the study were presented to the Panel in February of 1976 and were incorporated into the final Report of the Panel. The Panel emphasized that Federal support for research has strengthened the research capabilities of universities and academic medical centers, but pointed out that changing Federal policies and practices have begun to impose difficulties which could prove detrimental to the research capabilities of these institutions. The AAMC study and the Panel Report showed that research activities have continued to receive emphasis in academic medical centers, but that these research activities have not prevented academic medical centers from responding to societal demands for medical services and for increasing the supply of health manpower. The need for continued support of research training and for stability of research funding was emphasized strongly by both the ACE-AAMC-Rand study group and the Panel. The final Report of the Panel was submitted to the Congress and the President on April 30.

The President's Panel found that the NIH/ADAMHA was generally performing its major mission—biomedical research—very efficiently, and that the national research enterprise is addressing important problems. It recommended continued and strengthened research programs in the institutes and particularly called for an increase in the budgets for research at the National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism. The AAMC supported the Panel's recommendations for a continuation of a vigorous biomedical research program and for increasing the research budget in mental diseases, alcoholism, and drug abuse; however, the AAMC also recommended that the intramural research programs now located in ADAMHA be transferred to the NIH.

The Panel made several recommendations designed to improve the quality of scientific advice to the federal government. These recommendations would create an interlocking system of panels, councils, and advisors which the AAMC's Task Force felt would produce conflicting advice, overlapping responsibilities, and further weakening of the authorities of program managers. The Task Force believed that the Office of Science and Technology Policy would, with some modification, serve the same purpose better than would the recommendations of the President's Panel. Utilizing the OSTP as the body for the furnishing of biomedical and behavioral science advice to the President and the Office of Technology Assessment to serve an identical function for the Congress would produce more consistent advice than the recommendations of the President's Panel. The Task Force also recommended that science advice to the Director of NIH and Administrator of ADAMHA should be provided through a continuation of the present system.

The President's Panel did not recommend any significant changes in the organization of NIH/ADAMHA. The AAMC, however, believed that the national cancer effort was now well established and that there was no further need for a President's Cancer Panel or for the separation of the National Cancer Institute from the remainder of NIH.

The Task Force fully supported the Panel's recommendations that the investigator-initiated grant serve as the principal instrument for the support of research and that the NIH peer review process remain intact. Though the Association is concerned about the confidentiality of peer evaluation and review, the Task Force felt that it would not be wise to seek statutory exemption through modification of the Public Health Service Act, but rather through modification of the Federal Advisory Committee Act to permit confidential,

closed-panel review of grant and contract applications.

The Panel's recommendations addressed problems of instability of funding, budget formulation, and intramural and extramural program management which urgently need solution if the health of the academic institutions and the health of the biomedical research enterprise is to be assured; the AAMC Task Force agreed with and strongly supported their recommendations in these areas. The Association also specifically targeted for comment the Panel's recommendations on technology transfer, feeling that the limits of the NIH role should be more restrictively defined.

The AAMC has continued to be active in discussions of the ethics of biomedical research and the protection of human subjects. As a result of the activities of the AAMC, the public has become aware of the effects on biomedical research of the Freedom of Information Act and the Federal Advisory Committee Act.

A decision in 1974 by the U.S. Court of Appeals for the District of Columbia Circuit had the effect of requiring the release of research grant protocols under the Freedom of Information Act. Following this decision the Association began efforts to bring the unintentional effects of these laws on biomedical research to the attention of Congress. As a result, Congress asked the President's Biomedical Research Panel and the Commission for the Protection of Human Subjects to study the problem. Data gathered by NIH for these commissions indicate that revisions of the laws are indeed necessary. AAMC is continuing to work with public groups for clarification of these "sunshine laws," particularly as they affect the intellectual property rights of individual researchers, the protection of research subjects, the conduct of clinical trials, and other areas of biomedical research.

Throughout the year the funding of research training grants has suffered from continuing pressure by the Office of Management and Budget to eliminate Federal support for biomedical research training. Erosion of congressional support for training grants led to a decrease in the level of funds to a point below that needed to meet the recommendations of the National Academy of Sciences Human Resources Commission. To counter this erosion of support, the Association gathered information about the effects of cutbacks in research training funds and mobilized support to seek adequate funding levels. Because the perennial questioning of research training seems to be increasingly severe, AAMC has taken the leadership in coordinating a number of studies of research manpower. Acting on the recommendations of the Council of Academic Societies Conference on Biomedical Research Manpower, AAMC has brought together various groups including the Institute of Medicine, the National Academy of Sciences, and the National Institutes of Health to define the data needed and to see that it is gathered and analyzed.

# Health Care

In recent years interest among academic medical centers in both the study of and the development of model health care systems has accelerated. This interest has become manifest in numerous activities such as the restructure of ambulatory care services, increased affiliation with community-oriented health programs, and development of individual or group practice preceptorships. Elements contributing to this interest include institutional needs for additional sites offering high quality experience to increasing numbers of undergraduate students, institutional responses to societal pressures for increased health services to underserved communities, and the desirability of providing medical students at all levels with experiences in a variety of health care settings.

The Association has initiated several programs aimed at facilitating these activities. Following an initial project designed to document several prototypes of academic medical center health maintenance organization affiliations, the Association has recently completed the development of optimum curriculum for undergraduate and graduate physician training in the HMO model. The program, supported by the Bureau of Health Manpower, provided the support for such curriculum development in six affiliated HMO programs. Among the products of the programs have been descriptive model curricula for undergraduate and graduate medical student involvement, a generic set of evaluation instruments reflecting common educational objectives, a methodology for estimating the educational costs for both undergraduate and graduate students based on principles of cost-benefit analysis, and a role guide and resource book for clinical preceptors.

Consistent with the continued emphasis on primary education within the academic medical centers, the Association has this year resurveyed the nation's medical schools in an effort to identify the extent of institutional efforts in the education and training of physicians and nonphysicians as primary care providers. The results of an initial survey completed in 1973 were published in the September 1974 issue of the *Journal of Medical Education*. It is expected that the current 1976 survey will provide data to document changes which have occurred during the three year interim. Of particular interest to the Association will be an assessment of the degree to which these changes may have resulted from the impact of the 1974 AAMC-sponsored Institute on Primary Care and the subsequent regional primary care workshops conducted during the spring of 1975.

As a direct and incidental follow-up to these workshops, the Association last year developed a series of national workshops specifically designed for the purpose of assisting academic medical centers and their affiliated teaching hospitals in the improvement of ambulatory care services and related educational programs. That particular program, supported by the Office of Planning, Evaluation and Legislation of the Health Resources Administration, will continue this year and will provide an additional workshop plus on-site consultative services to participating institutions. It is anticipated that a guide to ambulatory care restructuring for the purposes of improving education and encouraging optimum one-class services will be developed.

Coincidental to the study and development of model health care programs for use as educational models, the appropriate implementation of quality assurance methodologies into the medical curriculum has been a subject of long interest to the Association. Several medical educators, noting that medical students receive relatively little instruction in evaluating the outcome of medical intervention on a scientific basis, have indicated interest in integrating the concepts and requisite skills necessary to perform quality assurance activities. The Association has sought to enhance this movement through sponsorship of several regional meetings relating to the subject of quality assurance methodologies and peer review procedures at the undergraduate level. Descriptions of several new concepts related to this curriculum development were featured in a symposium on quality assurance education contained in the May 1976 issue of the *Journal of Medical Education*.

# Faculty

During the past year the Association's faculty development program reached full implementation. Begun less than a year earlier, this effort is designed to raise the quality and efficiency of medical educational programs primarily by helping faculty members enhance their effectiveness as teachers.

Toward this end, plans were completed and pilot testing done in preparation for a national survey of a stratified, random sample of nearly 2,700 full-time medical school faculty members. This study will provide the first available overview of how medical teaching is conducted, what faculty members perceive as instructional problems, and whether there are areas in which they would like assistance to improve their instructional effectiveness. The findings will guide the Association in the development of services that will be offered to medical school faculty. In addition, the written simulations and questionnaires used in the survey will be refined to serve as the basis for the voluntary, confidential self-assessment program that will be offered to all faculty members during 1977. This project is supported by a contract with the Bureau of Health Manpower and by grants from the Kellogg Foundation and Commonwealth Fund.

A study of the factors associated with the choice of careers in biomedical research was begun in 1976, supported in part by a contract with the National Institutes of Health. This study will examine the more than 500 members of the medical school class of 1960 who have chosen a career on the faculty of U.S. medical schools, comparing them to their classmates who did not choose careers in academic medicine. As a related part of the study, AAMC is working to identify possible means by which the quality of research and teaching may be measured. This exploratory study will attempt to relate peer judgment of individual abilities in research and teaching to other measures of the quality of a faculty member's efforts, such as publication in top journals and service on advisory committees.

The Faculty Roster Project, initiated in 1965, continues to provide valuable information on the intellectual capital of medical education. The biographical information on faculty supplied to the Association by the medical schools serves as a mechanism to provide feedback in an organized and systematic matter to the institutions. For example, information on individual faculty by department was mailed to each medical school in June. The information was presented in a format designed to permit easy reporting by the schools on the Liaison Committee on Medical Education Questionnaire—Part II. The data contained in the faculty roster are also utilized by the Association for studies on such topics as faculty mobility, faculty attrition, participation of faculty in Federal programs, and career performance within academic medicine.

Several reports were generated this year using the Faculty Roster data base. Under contract with the Bureau of Health Manpower, work on a report entitled *Descriptive Study of Salaried Medical School Faculty* was completed. This report contains information on faculty appointment characteristics, educational characteristics, and employment history with various breakdowns by sex, minority group, and country of medical training. In recent years, the Association has received numerous requests for information regarding the current distribution of medical school faculty by sex and ethnic group. The publication *Participation of Women and Minorities on U.S. Medical Faculties,* released in March, is intended to serve these needs.

As of June, the Faculty Roster contained information on 44,724 individuals, an increase of 13% since June 1975. Including the addition of 5,051 new faculty members, 50% of the records contained in the data base have been updated in some manner.

The *1975-76 Medical School Faculty Salary Survey* was released in February by the Association. This year, for the first time, faculty positions were reported separately but within the same survey for the 16 Canadian medical schools. The inclusion of the Canadian schools accounts for 3,361 additional filled full-time faculty positions. In the 1975-76 survey, 30,487 full-time positions were reported. The survey, begun in the early 1960's and updated annually, continues to provide medical school administrators, department chairmen, and others with a valuable tool for reviewing faculty salary trends.

# Students

In the competition for 1976-77 first-year places, 42,000 applicants submitted 370,000 applications, reflecting for the first time in many years a slight decline in the number of individuals seeking admission. Yearly growth rates in enrollments have shown moderate advances in the last two years and the totals for 1976-77 are expected to be larger than the 15,295 freshmen and 55,818 overall enrollment reported by the nation's medical schools for 1975-76.

The application process was assisted by the Early Decision Program and by the American Medical College Application Service. For the 1976-77 first-year class, 58 medical schools participated in the Early Decision Program, and 1,046 students were accepted. Since each of the 1,046 filed only one application, the processing of about 8,000 multiple applications was eliminated.

AMCAS was utilized by 86 medical schools for the processing of first-year application materials. Besides collecting and coordinating admissions data in a uniform format, AMCAS provides useful rosters and statistical reports to participating schools. At the same time, AMCAS maintains a national data bank for research projects associated with admissions. The AMCAS program continues to be guided in the development of its procedures and policies by the Medical Student Information System Committee.

The AAMC, in cooperation with the National Board of Medical Examiners and the Bureau of Health Manpower, offered a special opportunity for Vietnamese refugee medical students to receive AAMC sponsorship to take NBME Part I in June. Vietnamese refugees who were students in good standing at one of the three medical schools in Vietnam immediately prior to their arrival in North America were eligible for this special sponsorship. Since in most cases such individuals did not have transcripts or other credentials available to them, their eligibility was confirmed to AAMC by former faculty of the three Vietnamese medical schools who had personal knowledge of each sponsored student. These students may use the scores as evidence of their competence when applying to U.S. medical schools.

The American College Testing Program continued responsibility at the direction of AAMC for operations related to the registration, test administration, test scoring, and score reporting procedures for the Medical College Admission Test. The number of MCAT examinees continued to decrease, as it has during the last two years. The estimate for 1976 is 55,000 examinations, down from 57,500 in 1975 and 58,200 in 1974. The significantly greater decrease for 1976 seems mostly accounted for by the GSA-sponsored requirement that all examinees applying to classes beyond 1977 must supply data from the New MCAT. Ordinarily, a certain percentage of the examinees take the exam in advance of the usual cycle for counseling purposes. These students apparently deferred taking the exam. This interpretation is supported by the significant increases in MCAT mean scores for the spring 1976 administration. These mean values were observed to be more typical of an applicant group than the usual examinee population.

In response to concerns expressed by a variety of the members of the medical education community over the increasing financial problems of medical students, a Task Force on Student Financing has been created with a two-year charge to examine existing and potential mechanisms for providing financial assistance to medical students. The task force will make interim reports to the Executive Council and may in its final report also make recommendations to the medical schools, federal and state governments, and private funding agencies. Also in the area of student aid, the Association supported an extension of the legislation which provided an income tax exemption to those students who were recipients of the Public Health Service/National Health Service Corps and Armed Forces Health Professions Scholarships.

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 regional groups of admissions officers, advisors, and medical school admissions committees. Admissions workshops were conducted for eleven schools. The publication *Minority Opportunities in U.S. Medical Schools* was updated in 1975 and distributed to admissions officers and advisors. This booklet provided detailed information about medical schools' programs which offer opportunities for

minorities. 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 the increasing concern over the number of lawsuits being filed against schools charging reverse discrimination in the selection of minority students, the survey conducted last year to determine the characteristics of suits and their outcome has been updated. The Association filed an *amicus curiae* brief in the case of *Bakke* v. *Regents of the University of California* which supported the position that special admission programs for minority students do not violate constitutional equal protection safeguards. The AAMC Task Force on Minority Student Opportunities in Medicine was established to make recommendations to improve opportunities for minorities seeking a career in medicine. An increasing number of minority students are now proceeding into the graduate phase of their medical education. A study 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.

The Association has taken the position that the United States should make available in its medical schools the number of places necessary to meet the need for physicians in future years so that undergraduate medical education abroad does not become a regular alternative to the study of medicine at home. The qualified U.S. citizen studying medicine abroad should, if resources can be made available, be admitted to advanced standing by the faculties of U.S. schools. The Association has advocated that policies and programs for these transfer students should be subjected to the scrutiny of the accreditation process and should supersede existing "Fifth Pathway" programs.

In 1975, the Coordinated Transfer Application System sponsored 769 U.S. citizens studying in foreign medical schools for Part I of the National Board of Medical Examiners. Of the 664 who were examined, 377 passed and 243 were accepted with advanced standing by U.S. medical schools. An additional 29 transfer students were admitted who had been sponsored directly by medical schools. The 18 percent decrease over the previous year in COTRANS-sponsored examinees was partially offset by an increase in the test pass rate.

In December 1975, three major student studies were completed under contract with the Bureau of Health Manpower. The Study of 1974-75 Applicants focused on changes from 1970-71 and showed substantial increases in women and underrepresented minorities. The Study of 1974-75 Enrollees compared the characteristics of these students by type of medical school (public and private) and by class level. The "Survey of How Medical Students Finance Their Education, 1974-75," updated similar surveys for 1963-64, 1967-68 and 1970-71 and revealed that seven out of ten medical school seniors were in debt by an average of $9,000 during 1974-75. Under an expanded BHM contract, the applicant and enrollee studies are being replicated for 1975-76 and the analysis of the data from the survey of student financing is being extended. This analysis shows that a gratifyingly high proportion of 1974-75 medical students reported an interest in primary care specialties (61 percent) and in practicing in underserved areas (47 percent).

The transition from undergraduate to graduate medical education has been receiving increasing attention from both inside and outside academic medicine. Pressure to place external regulations upon the number and type of residency positions available to graduates of U.S. medical schools may be in part ameliorated by the natural phenomena which have located nearly fifty percent of first year residents in the generally recognized primary care specialties. The total number of first year graduate positions available is now only 19 percent greater than the number of U.S. graduates applying for these positions. Current statistics suggest that virtually all primary care residency positions are being filled. The overall perspective on the trends in graduate medical education is becoming clearer due to the increasing availability of data from the National Intern and Resident Matching Program. The Executive Director of NIRMP attended all four regional meetings of the Group on Student Affairs and the spring meeting of the Council of Deans to present these data.

The Group on Student Affairs continued to play an active role in helping to guide the Association's student programs. Representatives of the GSA have played key roles in the AAMC consideration of student financing and minority student opportunities.

# Institutional Development

This past year represented the fourth year of the Management Advancement Program. Since its inception, the program has been both an educational effort and an opportunity for senior administrators from academic medical centers to develop institutional plans. The former objective, education, has been approached through the presentation of didactic lectures and through an open exchange between program participants and lecturers throughout the course of the various seminars. The latter objective, planned institutional change, is a longer term goal, which has been approached by including institutional representatives, aided by expert management consultants, in problem-identification and institutional planning sessions.

The Management Advancement Program was planned by an AAMC Steering Committee chaired by Dr. Ivan L. Bennett, Jr. The Steering Committee has sought the advice of a number of individual consultants and experts on design of the overall effort, and together they have continued to monitor program content and structure carefully.

Phase I, The Executive Development Seminar, is an intensive workshop in management technique and theory. Phases II and III, Institutional Development Seminars, permit a management team from each participating school to work on a real issue identified from within their own setting.

With the sixth Phase I, August 1976, over 100 deans have participated in the Executive Development Seminars. The follow-up seminars have involved 54 institutions in Phase II and 17 in Phase III. Over 500 individual participants have attended; in addition to the deans, 99 department chairmen, 55 hospital administrators, 19 vice presidents, 4 chancellors, as well as program directors, business officers, and planning coordinators have attended. Support for early program planning was provided by the Carnegie Corporation of New York and by the Grant Foundation. Two grants from the Robert Wood Johnson Foundation, the first a two-year award and the second a three-year award, have permitted full implementation of the program.

Requests for seminars from groups other than the target population have initiated consideration of alternatives for broadening the program audience. As academic medical centers have grown in size and complexity, the need to develop a larger critical mass of individuals informed of management concepts and techniques has become increasingly apparent. In an attempt to accommodate the growing demand for management information, the AAMC has negotiated an important new contract with the National Library of Medicine. The Management Education Network Project, initiated in the Spring of 1976, will expand the target audience of the Management Advancement Program. In addition, documentation of academic medical center institutional problem-solving will now be possible. Specific tasks identified include: 1) design of a management literature retrieval system; 2) development of audio-visual instructional packages around the subject matter presented in the MAP; 3) documentation of selected academic medical center managerial processes; and 4) exploration of the desirability and feasibility of simulation modelling as a management tool of medical school decision-makers. This project is monitored by an Advisory Committee chaired by Dr. J. Robert Buchanan.

Two projects were undertaken during the year with the objective of enhancing the understanding of medical school-teaching hospital relationships, particularly the complex of governance and management issues which these relations entail. The first project focused on the relations between the medical school and a principal teaching hospital. A panel of deans, hospital directors, and faculty members were queried as to their perceptions of the relative influence of eleven possible agents on each of the twenty-six decision areas involving both medical school and hospital. The panel was also asked to provide judgments as to the level of formal responsibility each agent bore for the resolution of issues in each area. Preliminary results of this survey were presented at the Council of Deans meeting and a final report will be contained in the proceedings of that meeting.

A second project is designed to investigate in detail the affiliation arrangements between a sample of six selected medical schools and the network of teaching hospitals with whom they are affiliated. This study, supported under contract with the Bureau of Health Manpower, follows a management perspective to examine the structure and pro-

cess of decision-making on specific areas of concern to both parties: assignment of students to clerkships, assignment of residents by specialty, initiation of new patient care programs, selection of education officers in the affiliate, allocation of research by sponsored programs, and the participation of volunteer faculty in the medical school decision-making process. The project is proceeding under the guidance of a project review committee chaired by Dr. Robert Massey and with the assistance of a liaison representative from each medical school in the sample. Substantial quantitative data and the reports of site visits will be analyzed to develop descriptions of the affiliation networks and to provide some assessment of what factors contribute to an effective leadership.

A Visiting Professor Emeritus Program has been established at the AAMC with support from the National Fund for Medical Education. The program was developed to fill temporary faculty positions in the medical schools with available emeriti professors. The substantial response to the announcement of the program early in July reflects the need for this service to the medical schools.

The Association maintains its interest in institutional development in Latin American countries in close collaboration with the Panamerican Federation of Associations of Medical Schools. Major efforts were devoted to the program, which assists the establishment of close relationships between social security institutions in Latin American countries and their medical schools. For this purpose, additional regional workshops were held, including preliminary and follow-up meetings with participating agencies and institutions. Representatives from Bolivia, Brazil, Paraguay, and Peru attended these workshops. Based on the favorable outcome of all five workshops held during the past two years, preparations have now been made for workshops to deal with specific issues relating to the development of collaborative programs between social security institutions and medical schools in three countries.

The AAMC also participated in a conference to formulate minimal standards for the development of new medical schools in Latin American countries. The sponsorship for this program stemmed from an agreement between PAFAMS and the Pan American Health Organization that the adoption of such minimal standards would have beneficial and long-range effects on medical education in Latin America.

During the past year the executive offices of PAFAMS moved from Bogota, Colombia to Caracas, Venezuela, and a new Executive Director, Dr. Francisco Kerdel-Vegas, was designated. The AAMC assisted the new Executive Director in the development of background materials for several projects, including a proposal for the initiation of a Panamerican Institute for the Training of Teachers of Health Associated Professions in Caracas, Venezuela.

# Teaching Hospitals

The Association's teaching hospital activities for 1975-1976 focused on the continuing governmental efforts at regulating the health care industry. Considerable Association activity was directed toward analyzing and responding to legislation, regulations, and special studies dealing with health care industry controls having a special impact on teaching hospitals.

The Institute of Medicine conducted an in-depth study of Medicare and Medicaid reimbursement practices pursuant to the direction of Congress in the 1973 Social Security Amendments. The charge to the Institute of Medicine was to study five major areas: (1) appropriate and equitable methods of reimbursement of physician services in hospitals having teaching programs; (2) the extent to which Federal funds were supporting the training of medical specialties which were in short supply; (3) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty; (4) the extent to which such funds support or encourage teaching programs which disproportionately attract foreign medical graduates; and (5) the existing and appropriate role of the Federal health care funds in meeting the cost of stipends of interns and residents.

The IOM study staff used teaching hospital site visits, survey questionnaires, and advisory panels to explore and evaluate present reimbursement practices. The Institute's final report, published in March, proposed significant changes in present reimbursement practices for some teaching hospitals. In responding to these recommendations, the Association has described three distinct physician services in teaching hospitals: direct and personal medical services; administration and supervision of the hospital and its organizational components; and teaching and instruction in medical education programs. While there are alternative procedures for reimbursing practitioners and providers of services, failure to reimburse legitimate costs of any of these three hospital services threatens the ability of teaching hospitals and physicians to fulfill patient care and medical education responsibilities. The Association has presented its views on this portion of the study as well as on those recommendations in the study directed at the issues of specialty and geographic distribution of physicians and foreign medical graduates to the IOM and the Congress.

The Medicare-Medicaid Administrative and Reimbursement Reform Act, introduced by Senator Talmadge, contains provisions affecting program administration, provider reimbursement, and practitioner reimbursement. During the development of the legislation, the Association actively discussed general concepts and tentative provisions of the bill with staff of the Health Subcommittee of the Senate Finance Committee. These meetings were informative and mutually beneficial. While the Association endorses many provisions of the Talmadge bill, several recommendations for revisions were presented in testimony before the appropriate subcommittees in both Houses. The Association's testimony concentrated on the proposal to replace the routine service cost limitations of Section 223 with a new cross-classification and cost limitation system. The Association was pleased to note that the proposed legislation excludes from the routine operating cost calculations and limitations: capital costs; direct education and training costs; costs of interns, residents, and medical personnel; and energy costs. However, the highly restrictive language of the bill resulted in the Association recommendations for a more flexible cross-classification system, for elimination of the category "primary affiliates of accredited medical schools," and for an examination of the implications of alternative definitions of "teaching/tertiary care hospitals." The Association is continuing to follow the development of this legislation and has been asked to assist the Subcommittee with constructive proposals and suggestions.

The Association's appeal of its suit on the implementation of routine service cost limitations under Section 223 is pending before the U.S. Court of Appeals for the District of Columbia Circuit. In the absence of court-ordered relief or legislation replacing the cost limitations of Section 223, the Association is actively monitoring the impact of this section on teaching hospitals. Throughout the year, the Association has encouraged the Bureau of Health Insurance to adopt an exception procedure for routine service costs limitations which pro-

vides: (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of comparable hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospitals' routine per diem operating costs without changing the per-admission costs. Apart from Intermediary Letters establishing procedures for adjustments for housestaff and nursing education costs, these efforts have had minimal success. Therefore, COTH members have been requested to provide the Association with a copy of all exceptions requests and correspondence so that member experiences may be shared. The Association also surveyed non-federal COTH members to assess the financial impact of these cost limitations. Survey findings indicate that at least twenty percent of all COTH member hospitals have exceeded the ceiling during the past two years; that COTH members most likely to exceed the ceiling are state or county owned, under 410 beds, and university-owned; and that the limitations are working to the disadvantage of the members with higher housestaff expenditures. The Association will continue to work with teaching hospitals and Bureau of Health Insurance representatives in hopes of improving the exception process and reducing the disproportionate impact of these limitations on COTH members.

During the year, the Association filed numerous comments with Executive Branch agencies on proposed regulations and activities including limitations on inpatient costs under Medicare and Medicaid, standards for personnel in clinical laboratories, requirements for State Health Coordinating Councils, procedures for Certificate of Need review, Medicare's draft proposal on recognizing self-insurance contributions as reimbursable costs, and the draft uniform accounting system being prepared by the Bureau of Health Insurance.

In March, the National Labor Relations Board announced its initial decision ". . . that interns, residents, and clinical fellows are primarily engaged in graduate training and are students rather than employees within the meaning of the National Labor Relations Act." Thus, the Board ruled that housestaff organizations at the involved hospitals could not invoke the protections of the National Labor Relations Act. The Board's decision was based on the factual evidence presented, and was not a policy decision. Thus, in any teaching hospital having housestaff but little instruction and training, such housestaff might be declared employees rather than students. Last year, in an *amicus curiae* brief submitted to the Board, the Association argued that interns and residents were primarily students and that designation of housestaff as employees would have a significant detrimental impact upon the structure, function, and content of graduate medical education.

Following Assembly approval, the Association initiated a Corresponding Membership category for teaching hospitals not eligible for COTH membership. Corresponding Members must have a documented affiliation agreement with a school of medicine and obtain a letter of support from the dean of the affiliated medical school. This type of membership is available to nonprofit and/or governmental hospitals. Benefits of such membership include notification of and eligibility to attend all open AAMC meetings and to receive all general AAMC publications and communications.

The Association's program of teaching hospital surveys combines four regular and recurring surveys with a limited number of special, issue-oriented surveys. The regular surveys are the Educational Programs and Services Survey, the House Staff Policy Survey, the Income and Expense Survey for University-Owned Hospitals, and the Executive Salary Survey. During the past year, each of these surveys had an excellent response rate from member hospitals. The findings of each of these surveys have been furnished to participating hospitals and, when appropriate, results have been publically distributed. Two special surveys were conducted this year: the Survey of the Impact of Section 223 and the Survey of Professional Liability Insurance in University-Owned Hospitals.

# Communications

The Association communicates its views, studies, and reports to its constituents, interested Federal representatives, and the general public through a variety of publications, news releases, news conferences, personal news media interviews, and memoranda. The major communications vehicle for keeping the constituents of the AAMC informed is the *President's Weekly Activities Report.* This publication, which is issued 43 times a year, reaches more than 9,000 readers. It reports on AAMC activities and Federal actions that have a direct effect on medical education, biomedical research and health care.

In addition to the *President's Weekly Activities Report,* other newsletters of a more specialized nature are: *AAMC Education News,* which is published five times each year and is circulated free-of-charge to all medical school full-time faculty members whose names are registered with the AAMC Faculty Roster; *The Advisor; COTH Report; CAS Brief; Student Affairs Reporter;* and the *OSR Bulletin Board.* Numerous other publications such as directories, reports, papers, studies, proceedings, and archival listings also were produced and distributed by the Association.

The *Journal of Medical Education* in fiscal 1976 published 1,042 pages of editorial material, compared with 1,242 pages the previous year. One supplement was published during the year: "Recruitment and Progress of Minority Medical School Entrants, 1970-1972." Special issues were devoted to teaching quality assurance and to the six-year curriculum. A 265-page book, *Perspectives in Primary Care Education,* was published as Part 2 of the regular December issue of the *Journal.* The plenary addresses from the 1975 AAMC Annual Meeting and the 1975 AAMC Proceedings and Annual Report also were published in the *Journal.*

Excluding the supplement and the Part 2 publication, a total of 152 papers (80 regular articles and 72 communications) were published, compared with 167 papers in fiscal 1975. The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine and initiated a new section for abstracts.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1975-76 totaled 404, compared with 422 and 397 the previous two years. Of the 404 articles received in 1975-76, 145 were accepted for publication, 177 were rejected, 24 were withdrawn, and 58 were pending as the year ended.

Pages of paid advertisements totaled 92 during the fiscal year, compared with 91 the previous year. As the year ended, the *Journal*'s monthly circulation was about 6,600.

In order to hold down production costs, the number of pages was limited to 96 in most issues, the composition-printing process used for the *Journal* was changed from "hot type" to "cold type," and a different grade of paper was used for the printing of the publication.

About 35,000 copies of the annual *Medical School Admission Requirements,* 4,000 copies of the *AAMC Directory of American Medical Education,* and 3,000 copies of the *AAMC Curriculum Directory* were sold or distributed.

# Information Systems

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

In addition to the annual "Study of U.S. Medical School Applicants," published in the *Journal of Medical Education*, the data base supports research and special reports on topical subjects. During the past year, these special reports included the *Descriptive Study of Medical School Applicants, 1974-75, Descriptive Study of Enrolled Medical Students, 1974-75,* and *Survey of How Medical Students Finance Their Education, 1974-75.*

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

Data descriptive of medical schools as institutions are managed by the Institutional Profile System, a computer-based information source containing approximately 10,000 data elements for each U.S. medical school. The primary sources of data for the Institutional Profile System have been recurrent 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. This objective is accomplished through use of an integrated data base and supporting computer software package that together allow immediate user retrieval of data via computer terminals. The Institutional Profile System is used to respond to ad hoc requests from medical schools and other interested parties, particularly requests for comparing one school's data to that of other schools. The system is also the source of data for regular descriptive reports as well as for numerous targeted research efforts on medical schools as institutions of higher education. In two years of operation, the IPS has grown from 1,500 variables for each medical school derived from three sources of data to approximately 10,000 variables for each medical school derived from more than 60 sources of data.

Use of the Institutional Profile System has increased significantly during the 1975-76 fiscal year. Over 350 specific requests for data have been filled directly by the IPS in less than two years of operation. The system is used heavily within the AAMC to support data requirements for targeted research and other activities.

The Association continues to serve as a primary source of teaching hospital information. Annual surveys are conducted to obtain house staff stipend information; income, expense, and general operating data for university-owned hospitals; data on executive salary remuneration; and general operating information for the COTH Directory of Educational Programs and Services. Special surveys conducted during the year collected information on medical school affiliation agreements, housestaff manual provisions, and teaching hospital status under Section 223 of the 1972 Social Security Amendments.

Two major studies were published during the year. For the eighth consecutive year the *COTH Survey of Housestaff Policy* was published. The survey describes the relationship between teaching hospitals and house officers and serves as a comprehensive source of data on housestaff stipends and fringe benefits. In February the Association published its sixth annual "Analysis of University-Owned Teaching Hospital Income, Expenses and General Operating Data." It provided an overview of income and expense trends for the fiscal year 1974 as well as statistical tables comparing the hospitals along selected income, expense, and operational dimensions.

# Treasurer's Report

The audited statements and the audit report for the fiscal year ending June 30, 1976 were carefully examined by representatives of the Association's auditors, Ernst and Ernst; by members of the Association Audit Committee; and by Association staff on September 1, 1976. At its meeting in Washington on September 17, 1976 the Executive Council reviewed and accepted the final unqualified audit report and the management letter containing the auditors' recommendations.

Total income for the year increased 8.73 percent to $8,667,131. Operating expenditures totaled $7,869,791.

Balances in funds restricted by the grantor decreased $139,568 to $288,846, while unrestricted funds available for general purposes increased $871,034 to $4,901,152—a reserve equal to 62 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. To assist in the achievement of this goal, a finance committee has been appointed by the Executive Council.

## ASSOCIATION OF AMERICAN MEDICAL COLLEGES
## BALANCE SHEET
June 30, 1976

### ASSETS

| | |
|---|---|
| Cash | $ 467,663 |
| U.S. Treasury Bills | 5,462,566 |
| Accounts Receivable | 904,889 |
| Deposits and Prepaid Items | 29,372 |
| Investments in Management Account | 863,789 |
| TOTAL ASSETS | $7,728,279 |

### LIABILITIES AND FUND BALANCES

| | |
|---|---|
| Liabilities | |
| Accounts Payable | $ 661,691 |
| Deferred Income | 756,970 |
| Fund Balances | |
| Funds Restricted for Special Purposes | 1,111,610 |
| Funds Restricted for Investment in Plant | 296,856 |
| General Funds | 4,901,152 |
| TOTAL LIABILITIES & FUND BALANCES | $7,728,279 |

## OPERATING STATEMENT
Fiscal Year Ended June 30, 1976

### SOURCE OF FUNDS

| | |
|---|---|
| Income | |
| Dues and Service Fees from Members | $1,535,516 |
| Grants Restricted by Grantor | 303,174 |
| Cost Reimbursement Contracts | 2,570,682 |
| Special Services | 3,433,833 |
| Journal of Medical Education | 64,315 |
| Other Publications | 198,337 |
| Sundry | 561,274 |
| TOTAL INCOME | $8,667,131 |
| Reserve for MCAT Development | 234,926 |
| Reserve for Special Minority Programs | 23,913 |
| Reserve for Special Legal Contingencies | 27,787 |
| Decrease in Restricted Fund Balances | 139,568 |
| TOTAL SOURCE OF FUNDS | $9,093,325 |

### USE OF FUNDS

| | |
|---|---|
| Operating Expenses | |
| Salaries & Wages | $3,348,201 |
| Staff Benefits | 500,932 |
| Supplies and Services | 3,456,620 |
| Equipment | 53,344 |
| Travel | 510,694 |
| TOTAL EXPENSES | $7,869,791 |
| Transfer to Restricted Funds for Special Purposes | 352,500 |
| Increase in Unrestricted Fund Balances | 871,034 |
| TOTAL USE OF FUNDS | $9,093,325 |

# AAMC Membership

| TYPE | 1974-75 | 1975-76 |
|---|---|---|
| Institutional | 109 | 111 |
| Provisional Institutional | 7 | 6 |
| Affiliate | 17 | 17 |
| Provisional Affiliate | 0 | 0 |
| Graduate Affiliate | 1 | 1 |
| Academic Societies | 56 | 59 |
| Teaching Hospitals | 396 | 396 |
| Individual | 2,149 | 2,026 |
| Distinguished Service | 35 | 42 |
| Emeritus | 65 | 70 |
| Contributing | 9 | 7 |
| Sustaining | 17 | 17 |

# AAMC Committees

### ADMISSIONS ASSESSMENT

Cheves McC. Smythe, Chairman
Jack Colwill
Joseph S. Gonnella
David Jeppson
Walter F. Leavell
John McAnally
Christine McGuire
Frederick Waldman
Leslie T. Webster

### AUDIT

Charles B. Womer, Chairman
Harry Prystowsky
Roy C. Swan

### BORDEN AWARD

Daniel X. Freedman, Chairman
Eugene Braunwald
Jack W. Cole
James J. Ferguson
Robert S. Stone

### CAS NOMINATING

Rolla B. Hill, Jr., Chairman
Floyd W. Denny
Ronald W. Estabrook
William L. Parry
James B. Preston
John E. Steinhaus
Frank E. Young

### COD NOMINATING

Leonard M. Napolitano, Chairman
John E. Chapman
John M. Dennis
Joseph M. Holthaus
Robert S. Stone

### COTH NOMINATING

Sidney Lewine, Chairman
Roy S. Rambeck
Charles B. Womer

### CENTENNIAL

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William G. Anlyan
Robert B. Howard
Russell A. Nelson
Charles C. Sprague
Daniel C. Tosteson

### CONTINUING MEDICAL EDUCATION TASK FORCE

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Clement R. Brown
Michael Caruso
Carmine D. Clemente
Phil R. Manning
William D. Mayer
Mitchell T. Rabkin
Edward C. Rosenow, Jr.
Neal A. Vanselow
John Williamson

### CONTINUING MEDICAL EDUCATION

William D. Mayer, Chairman
Richard M. Bergland
Clement R. Brown
Richard Caplan
Carmine D. Clemente
John E. Jones
Charles A. Lewis
Thomas C. Meyer
Mitchell T. Rabkin
Jacob R. Sukor
Stephen Tarnoff
David Walthall

### COORDINATING COUNCIL ON MEDICAL EDUCATION

*AAMC MEMBERS:*

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John A. D. Cooper
Ronald W. Estabrook

LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION

*AAMC MEMBERS:*

Richard M. Bergland
William D. Mayer
Jacob R. Suker

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

*AAMC MEMBERS:*

Jack W. Cole
Robert M. Heyssel
James A. Pittman
August G. Swanson

LIAISON COMMITTEE ON MEDICAL EDUCATION

*AAMC MEMBERS:*

Steven C. Beering
Ralph J. Cazort
Ronald W. Estabrook
John D. Kemph
Thomas D. Kinney
C. John Tupper

**DATA DEVELOPMENT LIAISON**

Richard Janeway, Chairman
Marion Ball
John C. Bartlett
David Diamond
Paul Gazzerro, Jr.
James Griesen
Mary Ellen Hartman
Miles Hench
Kenneth Kutina
James Leming
Marion Mann
Raymond H. Murray
Marvin F. Neely, Jr.
Bernard Nelson
John E. Pauly

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Ivan L. Bennett, Jr.
Leonard W. Cronkhite, Jr.
John A. Gronvall
Rolla B. Hill, Jr.
Robert G. Petersdorf

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Harry Eagle
John W. Eckstein
Merrel D. Flair
T. Stewart Hamilton
Charles Ludmer

**GOVERNANCE AND STRUCTURE**

Daniel C. Tosteson, Chairman
William G. Anlyan
Sherman M. Mellinkoff
Russell A. Nelson
Charles C. Sprague

**GROUP ON BUSINESS AFFAIRS**

STEERING

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William Hilles, Executive Secretary
Daniel P. Benford
Warren Kennedy
Donald H. Lentz
Richard G. Littlejohn
M. James Peters
Joseph L. Preissig
Ralph M. Rogers
Marvin H. Siegel
David A. Sinclair
C. N. Stover
Robert Walker
Sid R. Wallace
Marion E. Woodbury

**GROUP ON MEDICAL EDUCATION**

STEERING

Merrel D. Flair, Chairman
James B. Erdmann, Executive Secretary
Robert A. Barbee
Gunter Grupp
Christine McGuire
James R. Scholten
Robert F. Schuck
Gary E. Striker
Clyde E. Tucker

**GROUP ON PUBLIC RELATIONS**

STEERING

Helen M. Sims, Chairman
Charles Fentress, Executive Secretary

**GROUP ON PUBLIC RELATIONS (Continued)**

Terry R. Barton
Bill D. Glance
Hugh Harrelson
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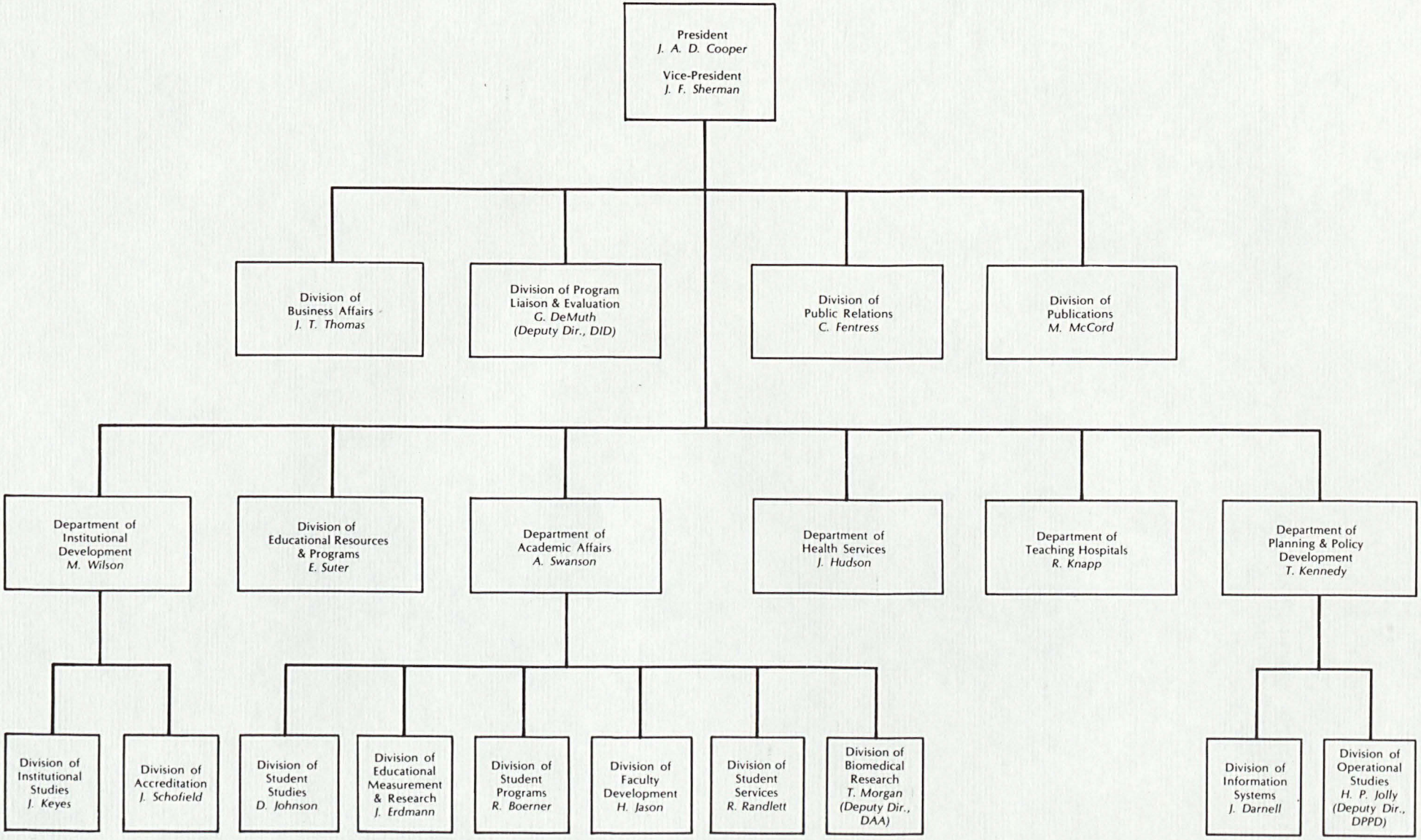


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