1976-1977 annual report

association of american medical colleges

Executive Council

Chairman
Ivan L. Bennett, Jr.

Chairman-Elect
Robert G. Petersdorf

President
John A. D. Cooper

Council Representatives:

Council of Academic Societies

Robert M. Berne
A. Jay Bollet
Rolla B. Hill, Jr.
Thomas K. Oliver, Jr.

Distinguished Service Member

Kenneth R. Crispell

Council of Deans

Stuart Bondurant
John A. Gronvall
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

David L. Everhart
Robert M. Heyssel
David D. Thompson
Charles B. Womer

Organization of Student Representatives

Thomas A. Rado
Paul Scoles

Executive Committee

Chairman
Ivan L. Bennett, Jr.

Chairman-Elect
Robert G. Petersdorf

President
John A. D. Cooper

Chairman, Council of Academic Societies
A. Jay Bollet

*Chairman, Council of Deans***
John A. Gronvall
Julius R. Krevans

Chairman, Council of Teaching Hospitals
Secretary-Treasurer
David D. Thompson

*deceased
**Dr. Gronvall served as Chairman from November 1975 until April 1977, at which time Dr. Krevans became the Chairman. Dr. Krevans will serve until November 1978.

1976-77 ANNUAL REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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Suite 200
Washington, D.C. 20036

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President's Message

The past year has been one of high expectations for the academic medical centers. It was assumed by many that a new Administration working with a Congress dominated by members of the same party would bring normalcy back to the government and, acting together, they would undertake thoughtful and constructive initiatives to get the nation moving again. There was hope that we would be spared the enervating battles of the past few years and be able to reestablish the private sector-government relationships that strengthened medical education, biomedical research and medical services so dramatically in the 1950's and early 60's.

These expectations have not yet been met. The President and the large staff of Georgians he brought to Washington have largely been occupied during the first nine months in office projecting the image of Jimmy Carter as a leader who will bring normalcy and respect back to the federal government. There has been little follow-up of campaign promises or development of explicit policies and specific legislation. The White House has had to learn, often the hard way, how to operate on the Washington scene and establish constructive relationships with the Congress. The wholesale removal of key agency heads in DHEW before Inauguration Day and the delay in replacing them and in appointing an Assistant Secretary for Health have exacted their toll on programs vital to the academic medical centers. It has been difficult for the bureaucracy to understand and participate in Secretary Califano's unconventional style of management. His sharp rhetoric has often created heat rather than shed light on the subject. As a consequence, we remain mostly in the dark on Administration policies on health matters.

At the President's request, the Congress postponed substantive action on expiring legislation for the National Cancer Institute, the National Heart, Lung and Blood Institute and the support of biomedical research training. Thus, there has been no clear enunciation of policy on biomedical research and training. The fears engendered in a group of university presidents who met with President Carter by the questions he seemed to have about the value of basic research have been somewhat allayed by a clarification provided by Frank Press, the President's Science Advisor.

While Administration policies on many health issues remain a mystery, there has been no equivocation on controlling health care costs. Viewed as a necessary precursor to national health insurance, cost control is the Administration's number one priority and only real initiative to date in the health field. In addition to emphasizing preventive medicine, education of the public, and the promotion of alternative delivery systems, the Carter plan would impose a nine percent cap on increases in hospital expenditures. Agreement of the House and Senate on cost control legislation may not be achieved before adjournment, but it is almost certain to be enacted in some form during the next session of Congress. The teaching hospitals face a difficult challenge in maintaining their critical contributions to education, research, and service under growing governmental restrictions and regulation.

The long-awaited health manpower law, in many respects infinitely better than earlier bills considered by the House and Senate, was seriously flawed by the now infamous "USFMS provision." While the schools were unanimous in their opposition to its infringement on the fundamental academic decision-making process, it was not clear how many institutions would or could refuse to comply. Even less clear was how the program would operate, if it could be administered at all. The confusion over this section was best summarized by Federal District Court Judge Edward Becker, who, in ruling against

Guadalajara students seeking enforcement of the provision this year, called the law "far from a model of lucidity."

The officers and Executive Council of the Association wrestled uncomfortably with the political dilemma of seeking amendment of the law at the risk of gaining little or nothing while sacrificing other provisions. While working to obtain legislative relief, we also labored hard to get regulations which would make this program manageable and maximize its acceptability to the schools. The Congress was finally convinced to reexamine this section of the manpower law and to initiate constructive amending legislation. But the medical schools may yet pay a price for this activity. With the law now reopened for amendment, Congressional reconsideration of other capitation conditions has been promised for next year. It appears that we will have rolling legislation, subject to review and change each year, providing little of the stability for which we had hoped.

Despite these problems, there is some cause for advancing our great expectations to the next year. Although we clearly cannot expect a return to the climate of the Sixties, particularly where federal expenditures are concerned, several of the Administration's appointments in the health and science areas offer hope for enlightened leadership in the future. If this leadership is assertive, perhaps the Administration and Congress can begin to work more effectively with the private sector in confronting the serious health problems that face the nation. Given proper roles, the academic medical centers can participate in the development of solutions. Given inappropriate roles, their ability to make unique contributions to society may be lost.

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

Administrative Boards of the Councils

Council of Academic Societies

Chairman
A. Jay Bollet

Chairman-Elect
Robert M. Berne

F. Marion Bishop
Eugene Braunwald
Carmine D. Clemente
G. W. N. Eggers, Jr.
Daniel X. Freedman
Rolla B. Hill, Jr.
Thomas K. Oliver, Jr.
Roy C. Swan
Samuel O. Thier
Leslie T. Webster

Council of Deans

*Chairman***
John A. Gronvall
Julius R. Krevans

Steven C. Beering
Stuart Bondurant
Christopher C. Fordham, III
Neal L. Gault, Jr.
William H. Luginbuhl
Clayton Rich
Chandler A. Stetson*
Robert L. Van Citters

Council of Teaching Hospitals

Chairman
David D. Thompson

Chairman-Elect
David L. Everhart

John W. Colloton
Jerome R. Dolezal
James M. Ensign
Robert M. Heyssel
Baldwin G. Lamson
Stuart Marylander
Stanley R. Nelson
Mitchell T. Rabkin
Malcom Randall
John Reinertsen
Robert E. Toomey
Charles B. Womer

AHA Representative
William T. Robinson

Organization of Student Representatives

Chairperson
Thomas A. Rado

Chairperson-Elect
Paul Scoles

Robert Bernstein
Robert H. Cassell
Margaret Chen
Jessica Fewkes
Cheryl Gutmann
James Maxwell
Richard S. Seigle
Peter Shields
Jon Christopher Webb

*deceased
**Dr. Gronvall served as Chairman from November 1975 until April 1977, at which time Dr. Krevans became the Chairman. Dr. Krevans will serve until November 1978.

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 Retreat of the elected officers and executive staff was held in December prior to the first meeting of the Executive Council. The Retreat participants reviewed the membership structure of the Association, particularly its relationship to member institutions and organizations representing university presidents and vice presidents for health affairs. The Retreat focused most of its attention on major issues either of immediate concern or which were expected to confront the Association within the coming year. Specifically discussed were national health insurance, efforts to amend the National Labor Relations Act to cover housestaff, strengthening the Organization of Student Representatives, and implementation or possible modification of the new health manpower law.

At its January meeting the Executive Council reviewed and approved the detailed report of the Officers' Retreat. Extensive discussion on the health manpower law produced agreement with the Retreat recommendation that the Association not seek modification of the law. Although there was unanimous agreement on the undesirability of the controversial USFMS provision, Council members felt that there was little chance for modification and that other parts of the new law should not be jeopardized. It was felt that the potentially harmful effects of this provision could be alleviated by implementing regulations which were sensitive to the position of the schools. The Council asked the AAMC staff to work closely with HEW regulation writers in order to assure the smooth operation of this program.

Another provision of the new health manpower law came under close Executive Council scrutiny. New limitations on the granting of visas to alien physicians were strongly supported by the Executive Council. However, Council members supported a one-year blanket waiver of the new law in order to allow the appropriate examinations to be put into place. The Executive Council pressed for speedy implementation of these provisions following the one-year hiatus, while supporting a narrow exception to allow distinguished physician visitors to enter the country.

Consistent with these new limitations on exchange visitors, the Executive Council asked the Liaison Committee on Graduate Medical Education to withdraw recognition of ECFMG certification based upon passing the ECFMG examination and to require instead that all physicians educated in medical schools not accredited by the Liaison Committee on Medical Education be required to have ECFMG certification based upon passing Parts I & II of the National Board of Medical Examiners examination or an equivalent examination prepared by the NBME in order to be eligible to enter accredited graduate medical education programs in the United States.

The Executive Council continued its careful periodic review of the actions and activities of the Coordinating Council on Medical Education and the three accrediting liaison committees. Of particular concern this year was the staff support provided by the American Medical Association to the CCME and the Liaison Committee on Graduate Medical Education. Although each of these groups has discussed possible changes in staffing and its implication on the financing of the organizations, no concrete proposals have yet been advanced. Staffing and financing of the LCGME, which now reviews the actions of Residency Review Committees and accredits all programs of graduate medical education in the United States, will continue to be a major issue in the coming year.

The Executive Council continued to review all policy-related actions of the LCME, this year approving LCME Guidelines to the Function and Structure of a Medical School. These guidelines elaborate on the published accreditation policy contained in the document "Function and Structure of a Medical School," and are designed to assist site visit teams in evaluating the programs of

an institution. In response to a request from the Office of Education and its Advisory Committee, which reviews all federally recognized accrediting agencies, the Executive Council agreed to reiterate its delegation to the LCME of final authority on all accreditation decisions. The Executive Council also authorized the LCME to develop its own prospective budget, to establish formal criteria for the appointment of members, and to adopt its own operating procedures. The Executive Council reserved authority to grant final approval to the establishment and revision of educational standards.

In response to a recommendation of the Retreat, the Executive Council appointed two major task forces. The first, the Task Force on Graduate Medical Education, was charged with reviewing the entire field and presenting recommendations to the Executive Council on how graduate medical education in the United States should develop programmatically, structurally, and institutionally. This Task Force is chaired by Dr. Jack Myers of the University of Pittsburgh School of Medicine. The second, the Task Force on the Support of Medical Education chaired by Dr. Stuart Bondurant of Albany Medical College, has begun discussions with key federal policy makers in pursuit of its charge of recommending to the Executive Council appropriate mechanisms for federal support of medical education after the expiration of the current health manpower law.

Two major AAMC task forces appointed during the previous year presented interim reports to the Council this year. The Task Force on Student Financing, chaired by Dr. Bernard Nelson, analyzed the shortcomings of current student financial aid programs and proposed a new federal Guaranteed Student Loan Program which would have more support from the banking community. The Task Force on Minority Student Opportunities in Medicine, chaired by Dr. George Lythcott, presented a series of recommendations on recruitment, retention, counselling, and assessment of minority students. Final reports from each of these Task Forces are expected during the coming year.

The Executive Council continued to enter important legal disputes where it felt that the issues before the court were of general and major concern to the medical schools and teaching hospitals. The Association filed an *amicus curiae* brief in the United States Supreme Court in the case of *Regents of the University of California* v. *Bakke*, asking that the Court uphold the constitutionality of special minority admissions programs in medical schools. The Association also filed an *amicus* brief in the case of *Kountz* v. *State University of New York*, asking the New York Superior Court to reverse the lower court ruling that the school's faculty practice plan was an unlawful confiscation of personal income. At the request of several New York hospitals, the Association filed several briefs in New York state and federal courts urging that the National Labor Relations Board had pre-empted state labor boards from taking jurisdiction over hospital/housestaff relations. A ruling by the United States Court of Appeals for the Second Circuit agreed with the Association's position.

The Executive Council this year responded to a request from the Liaison Committee on Specialty Boards for an Association position on recognition of emergency medicine as a new specialty. The Executive Council at first agreed that the Association should take no substantive position on this question, indicating that these broad policy decisions fall within the scope of review of the CCME. The Council also asked that the petitioning board be required to present a detailed statement of the financial impact of recognition of a new specialty. Following LCSB approval of the formation of an American Board of Emergency Medicine, the Executive Council appointed a small working group to recommend an AAMC position when this matter came for a final vote before the American Board of Medical Specialties. The Executive Council adopted the working group's recommendation that a conjoint board in emergency medicine be established with mandatory representation from family practice, internal medicine, pediatrics, and surgery.

Members of Congress asked the Executive Council to take a position on the continued federal support of the Uniformed Services University of the Health Sciences, which had been opposed by the Carter Administration. The Council reaffirmed its position that the Association should only speak to the quality of the educational program at the military medical school and should not take sides on the political controversy of its cost effectiveness. It was agreed that the Association should help place currently enrolled USUHS students in other U.S. medical schools and should assist the faculty in finding new positions if the Congress decided to close the school. Congress subsequently voted to continue funding for at least one year.

The Executive Council adopted indepth responses to several major studies affecting academic medicine. An HEW Proposal for Credentialling Health Manpower was reviewed at considerable length with Council members expressing concern over the economic impact of increased specialization and credentialling of health personnel. A Government Accounting Office report, "Problems in Training an Appropriate Mix of Physician Specialists," was generally supported by the Coun-

cil members. Its recommendation that the CCME accept the responsibility for recommending the appropriate distribution of residencies was supported, but it was agreed that the CCME should not be responsible for enforcing or implementing these recommendations. A National Academy of Sciences report on "Health Care for American Veterans" was analyzed by the Executive Council and support expressed for expanding and strengthening affiliation agreements between medical schools and VA hospitals.

At the request of the Council of Deans, the Executive Council appointed a small working group to consider the ethical issues raised when physicians withhold patient services in order to accomplish financial or political objectives. The Executive Council agreed that the Association, as the representative of academic medicine, should take a stand on this moral dilemma. The working group will prepare a recommendation for the Executive Council, which will ultimately be presented to the AAMC Assembly.

During the year the Executive Council continued to oversee the activities of the five Association Groups. Rules and regulations revisions were approved for several of these sub-council organizations and guidelines were approved for the newly created Minority Affairs Section of the Group on Student Affairs. The Association receives progress reports on Group activities twice each year.

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 Secretary Joseph Califano in June to discuss issues of major concern to the academic medical centers and to inform the Secretary about ways in which the Association might be of assistance.

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 1978. At the recommendation of the Association's legal counsel, the Executive Council has approved and recommended to the Assembly a Bylaws amendment adding a provision for the indemnification of AAMC officers and directors.

COUNCIL OF DEANS

The Council of Deans sponsored three programs at the 1976 Annual Meeting in San Francisco. The first program was co-sponsored with the OSR and entitled "Educational Stress: The Psychological Journey of the Medical Student." This program featured a keynote address dramatizing and describing many of the anxieties and conflicts students experience in medical school. This was followed by four student presentations elaborating perceptions of the major causes of the stresses they face: inadequate role models, inappropriate grading and evaluating systems, too many demands on their time and financial burdens. The program concluded with a dean describing his perspective on the institutional causes of stress and how it could be managed or reduced in the medical school setting. The second program was entitled "Current & Choice: Developments in Medical Education." Representatives of six schools describe a wide variety of imaginative developments at their own institutions. Subjects covered included innovative outreach service and educational programs, the development of more effective medical school-hospital relationships, an interdisciplinary curriculum on social and moral values, an institutional program on comprehensive primary patient care education, and experience with an independent study program. The third program was co-sponsored with the Council of Teaching Hospitals and focused on the activities of the Commission on Public General Hospitals. The two major presentations elaborated the approach of the Commission to dealing with issues for state university-owned hospitals and those related to big city public teaching hospitals.

The November Business Meeting included a presentation of reports from the Chairman, the President, and representatives from selected AAMC committees. The activities of the Association for Academic Health Centers were described in detail. The Council endorsed the Executive Council recommendation that the AAMC Bylaws be amended to authorize a second voting OSR representative on the Executive Council. The Chairman of the Association's Data Development Liaison Committee reported on that committee's deliberations regarding recommended policies and procedures for handling medical school data maintained by the AAMC. In its discussion of the program ahead, the Council reviewed the planning for its 1977 Spring Meeting and considered items to be presented to the AAMC Officers' Retreat. The Council received a number of items for information including a report on the Coordinating Council on Medical Education, the Liaison Committees concerned with accreditation, the status of the new MCAT, and progress reports from the AAMC Groups. Under new business the Council discussed the impact of the recently enacted health manpower legislation and passed a resolution in opposition to the provision mandating acceptance of U.S. students in foreign medical schools. Finally,

the Council expressed its unanimous appreciation for the service of Dr. J. Robert Buchanan, who had resigned as the Council's Chairman-Elect.

The Administrative Board met quarterly to carry on the business of the Council. It deliberated on all Executive Council items of significance to deans. Of particular interest to the Board was sharing with the OSR Administrative Board its understanding of the impact of placing housestaff negotiations under the provisions of the National Labor Relations Act. This topic was a subject of discussion at a joint dinner of the two Boards. The Board was also particularly concerned about the ethical issues raised by the increased tendency of groups of physicians to withhold professional services as a means of pursuing personal or political objectives. Thus, the Board initiated consideration of this matter by the Executive Council and stimulated the appointment of a committee to study and recommend an Association position.

The Council of Deans held its Spring Meeting in Scottsdale, Arizona, continuing the tradition of an annual three-day retreat devoted to an issue of current significance to deans. The theme of the program "Graduate Medical Education: Do We Have To Do Business in The Same Old Way?" was elaborated on by 22 speakers and panel members. Fourteen Canadian Deans, four COD Distinguished Service Members and the COTH Chairman joined with 91 institutional representatives for a comprehensive look at the issues surrounding the role of the medical school in graduate medical education. An historic retrospective traced the factors leading to the recommendation that the university begin to assume comprehensive responsibility for medical education through the graduate level and was followed by a status report derived from the recent experience of the NIRMP. The underlying public concerns which suggest the prospect of increasing control by government and third party carriers were sketched by several speakers. Alternate models for preparing the physician for practice which would integrate more closely premedical, medical and graduate medical education were proposed as ways to implement the concept that the award of the M.D. degree should be based on the demonstrated competence to practice medicine independently. The institutional response to the concept of corporate reponsibility for graduate medical education was discussed and one particularly successful experience was described. Finally, a Canadian dean provided a lucid and comprehensive review of the Canadian experience with substantial governmental involvement in medical care and medical education in that country. The meeting concluded with a business session which provided for general discussion of many matters of concern. The Council endorsed the proposal that a Telephone Alert Network be established as a means of informing the institutions of urgent matters requiring their immediate response. The meeting closed with a comprehensive review of the Bureau of Health Manpower's approach to the implementation of some of the more complex and controversial provisions of the Health Manpower Act.

In June, the Administrative Board resolved to dedicate the Proceedings of the Spring Meeting to the late Dr. Chandler A. Stetson in recognition of his substantial contribution to the AAMC, including his service as Chairman of the 1977 Spring Meeting program planning committee.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies made significant progress in coordinating the activities of its members and improving their interactions with the AAMC, with each other, and with the public sector.

During 1976, a number of CAS societies evinced growing concern about the increasing federal intrusion into all of the activities of academic medical centers. The societies expressed their desire for increased participation in the legislative and executive process. Responding to these interests, the CAS sponsored a Public Affairs Workshop last December. The objective of the workshop was to acquaint the Public Affairs Representatives with the intricacies of Congressional and Executive Branch procedures. More than 30 newly appointed Public Affairs Representatives, who will assume primary responsibility for interfacing with their members and the AAMC in the arena of public affairs, attended the workshop.

The CAS *Brief*, first published in the fall of 1975, now appears quarterly and is circulated to the officers and official representatives of the 61 member societies. Additionally, eight societies now distribute the *Brief* to all their members. This brings the total CAS *Brief* circulation to just under 8,000 readers. In response to a recent poll, 16 additional societies expressed interest in distributing the *Brief* to another 12,000 individuals.

Forty-seven societies were represented at the CAS Interim Meeting at the AAMC Headquarters in June. Current policy issues in biomedical research, medical education, and health care involved the participants in a vigorous exchange of information. Of foremost interest was the matter of legal restraints on the freedom of inquiry as proposed in legislation to regulate recombinant DNA and clin-

ical laboratory research. As a result of this meeting, many societies individually contacted key policy makers. Another Interim Meeting is planned for January 1978. Stimulated by a request from the Association of Professors of Medicine, a CAS Services Program has been established on a two-year experimental basis. This provides an opportunity for member societies to obtain certain services through the staff and facilities of the Association. These services include maintaining membership lists, providing billing and accounting services, making plenary and committee meeting arrangements, and preparing newsletters and memoranda on subjects of special interest to a society. It is anticipated that the Services Program will further solidify the CAS and enhance its effectiveness in dealing with the multiple challenges facing academic medicine. During the two-year experimental period, the best approach to providing services on an affordable basis to all member societies will be sought.

COUNCIL OF TEACHING HOSPITALS

Because reimbursement limitations and legislated cost containment programs can threaten the financial stability of teaching hospitals by failing to adjust for cost differences resulting from atypical diagnostic patient mixes and more intensive patient services, the Council, at its annual business meeting, sponsored a review of current developments in quantifying diagnostic case mix. Clifton R. Gaus, Director of the Division of Health Insurance Studies of the Social Security Administration, reviewed the federal concern with the costs of differing case mixes using data from the Medicare program; Professor John Thompson of Yale University described an ongoing research program in patient classification that is providing an essential methodological base for several case mix studies in COTH member hospitals; Charles Wood, Director of the Massachusetts Eye and Ear Infirmary, reviewed his hospital's practice of charging patients for routine services based on the intensity of service provided; and Baldwin Lamson, Director of the UCLA Hospital and Clinics, demonstrated how case mix at UCLA had been used to explain and document changes in the hospital's budget.

During the year, the COTH Administrative Board held quarterly meetings to develop the Association's program of teaching hospital activities and to consider and act on all matters brought before the Executive Council of the Association. Preceeding three of the Board meetings, evening sessions were held to provide seminar discussions on specific issues of concern to teaching hospitals.

At the January meeting, Mr. Thomas M. Tierney, Director of the SSA Bureau of Health Insurance, reviewed controversial policies and issues faced by the Medicare program. In a dialogue with Board members, he discussed federal concerns and decisions on the treatment of nursing education costs and reviewed their implications for medical education program expenses. Mr. Tierney concluded by suggesting that, in his personal view, government health care programs—including Medicare—must eventually replace present payment approaches requiring individual patient bills and records in order to avoid being buried in an ever increasing amount of paperwork.

At its March meeting, the Board devoted the majority of its attention to the report from the Association's Ad Hoc Committee to Review the Talmadge Bill. The Board recommended that the Executive Council modify the Committee's recommendations on state cost control programs and the classification of tertiary care/teaching hospitals before adopting the report as Association policy. These changes were approved by the Executive Council and the revised report provided the basis for the Association's subsequent testimony on the Talmadge Bill.

Robert A. Derzon, the first Administrator of HEW's new Health Care Financing Administration and a former COTH Chairman, met with the Board at its June session. He reviewed the reorganization of health financing activities within HEW and described some of the organizational problems faced by HCFA. Mr. Derzon concluded by emphasizing Secretary Califano's commitment to the Carter Administration's cost containment proposal.

At its June business meeting, the Board reviewed the Administration's proposed "Hospital Cost Containment Act of 1977." David Everhart, COTH Chairman-Elect and Chairman of the Association's ad hoc committee on the Administration's hospital cost control proposal, summarized the Committee's analysis of the Administration's proposal and reviewed policy positions recommended by the Committee. The Board strongly supported the Committee's analysis and recommendations.

At the September meeting Joseph Onek, Associate Director of the Domestic Council, reviewed the Administration's health policies, especially its proposal to limit hospital revenues and capital expenditures.

As a result of the Carter Administration's decision to advocate an immediate short-term program to modify the rate of hospital cost increases, this year's Administrative Board activities were heavily focused on proposals to change the Federal Govern-

ment's hospital payment practices. Other major topics of attention included legislation and court suits designed to define house staff as employees for purposes of the National Labor Relations Act, proposed JCAH guidelines for surveying university-owned hospitals, and the Association's management advancement program for COTH executives.

ORGANIZATION OF STUDENT REPRESENTATIVES

In its sixth year of operation, membership in the Organization of Student Representatives continued at a high level, with 112 of the nation's medical schools represented. At the 1976 Annual Meeting, over 100 students representing 94 schools attended business meetings, discussion sessions, and a joint OSR-Council of Deans program entitled, "Educational Stress: The Psychological Journey of the Medical Student."

Also at the Annual Meeting, OSR representatives approved a revision to the OSR Rules and Regulations to provide for the office of Chairperson-Elect. As a result of this action and of a change in the AAMC Bylaws, approved subsequently by the Assembly, the OSR now holds two voting seats on the AAMC Executive Council.

During the year, the OSR Administrative Board held quarterly meetings to discuss issues of concern to medical students and to act on all matters brought before the Executive Council. In a joint meeting last January, the OSR and COD Administrative Boards shared widely differing viewpoints on housestaff unionization. At this session and at other times during the year, the OSR urged the AAMC to seek ways of improving the educational and patient care aspects of those graduate training programs which participating house officers consider marginal in quality.

The OSR, through its members on AAMC task forces, maintained keen interest during the year in the problems of medical student financing, in the opportunities for minorities in medicine, and in graduate medical education.

A continuing priority for the OSR during the year was the problem of stress in medical education. This spring, the OSR surveyed students and student affairs deans of all U.S. medical schools to learn the types of psychological counseling that are offered by the schools and those counseling systems that seem to be most effective in meeting the needs of students.

In an effort to improve communications between the OSR and the approximately 60,000 U.S. medical students, the Association began publishing, on a trial basis, a newsletter to be distributed free-of-charge to all medical students. The *OSR Report* is intended to inform medical students of the nature and scope of the AAMC's involvement in national policy issues affecting medical education. The two editions published to date were distributed to all medical students via the local OSR representatives.

As in previous years, the OSR held regional spring meetings in conjunction with the AAMC Group on Student Affairs and the regional Associations of Advisors for the Health Professions. These meetings traditionally provide an opportunity for OSR representatives to interact with medical school student affairs officers and to learn about activities and programs of the AAMC.

National Policy

During the past year the Association has operated within a national arena that has undergone dramatic changes since the last Annual Meeting. The election of 1976 produced a new President, eighteen new Senators, and sixty-seven new members of the House of Representatives. These changes brought a new Administration to Washington, including a new cast of characters in the top health positions in DHEW, and caused a realignment of the leadership in both houses of Congress. In addition, the Senate made an effort to bring more efficiency to its operations by reorganizing its committee system for the first time since 1946.

The new Administration got off to an uncertain start in health when, following the appointment of a new Secretary, several key senior health officials were quickly swept from office. Despite the uncertainty of who would comprise the health leadership, the Association made a vigorous effort to inform the Carter health leaders about the AAMC, its constituency, and its position on relevant issues. Association staff met with members of the Carter transition team prior to the inauguration and with other top officials thereafter, culminating in a meeting between the Association's Executive Committee and HEW Secretary Joseph A. Califano, Jr. in June. Association staff also conveyed similar information to new members of the staffs of the Congressional health committees.

Even though President Carter had announced that it would take over a year to prepare his promised national health insurance proposal, in April he submitted a major legislative proposal designed to reduce the rapid rate of increase in health care costs. As this year's only major initiative in the health area, the Congress immediately seized upon cost containment as one of the major items for consideration during the 95th Congress. A series of hearings was quickly held by the four House and Senate subcommittees with jurisdiction over the legislation and four alternative pieces of legislation were developed. Senator Herman Talmadge (D-Ga.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, reintroduced a revised version of the Medicare and Medicaid Administrative and Reimbursement Reform Act which he had originally sponsored during the last Congress as still another viable alternative to the President's proposal. In testimony presented to both House and Senate subcommittees, the Association strongly opposed the Administration's proposal, contending that it was unreasonable in the short-run to place arbitrary controls on a single sector of the economy and in the long run would have adverse effects upon our nation's ability to rationally limit hospital expenditures. The Association was generally supportive of the Talmadge bill and recommended several modifications to provide more flexible provisions. In developing a position on behalf of the medical schools and teaching hospitals, the Association relied on two ad hoc committees, one which reviewed the Talmadge bill and one which reviewed President Carter's hospital containment proposal.

The Association's officers and staff devoted considerable time and attention this year to the implementation and reconsideration of the Health Professions Educational Assistance Act of 1976, which became law in October of 1976. As the Bureau of Health Manpower, DHEW, began the formidable task of developing regulations to implement this act, it became apparent that major technical problems existed and that the development of regulations would be a nearly impossible task. Most controversial among the provisions of the new law was Title V, which makes the receipt of capitation awards contingent upon the medical school reserving spaces for the transfer of United States citizens enrolled in foreign medical schools. This section precluded schools from refusing to admit these students on academic grounds if they had passed Part I of the National Board examination. Although the insertion of the transfer provision during the House-Senate conference on the manpower bill came as a complete surprise to the AAMC, the Association, after a survey of the deans, urged that President Ford sign the bill while indicating the desirability of amending it at a later date. The opposition of the medical schools to this provision was underscored at the 1976 Annual Meeting when the Council of Deans adopted a resolution condemning this provision for intruding into the academic prerogatives of the institutions. Since that time, the Association has actively participated in the writing and reviewing of regulations to minimize the intrusiveness of the provision and

has constantly explored the possibility of modifying or deleting the provision. Largely due to the efforts of the Association membership and the university community, Congress has begun to move toward modification of the onerous part of this provision.

Another provision of the new health manpower law, designed to curtail the immigration of foreign trained physicians, required substantial AAMC involvement to implement. The Association participated in discussions leading to the establishment of a Visa Qualifying Examination for foreign physicians, and supported the one-year general waiver of this requirement until the VQE could be offered. The Association has opposed a further extension of this waiver, feeling that the objectives of the law are laudable and that it should be enforced. Only to the extent that foreign physicians are unable to pass the VQE or the English language requirement of the law and thus be deemed unqualified would this law be exclusionary. The Association supported a carefully limited exemption from these requirements for distinguished visitors.

In addition to involving itself with the implementation of the 1976 health manpower law, the Association has begun to prepare for the renewal of this legislation in 1980. A Task Force on the Support of Medical Education was appointed and charged with recommending an AAMC position and strategy in anticipation of Congressional reconsideration.

The federal appropriation process was complicated this year by the passage of several pieces of authorizing legislation after enactment of the 1977 appropriation and by the mid-year change of Administration. Funding of the new health manpower law required a supplemental to the 1977 appropriation, which the Congress passed in May. Enactment of the 1978 Labor-HEW bill has been considerably more difficult. President Carter's budget request for 1978 acknowleged that his Administration had not had time to revise substantially the budget submitted by President Ford. The Congress realized this and significantly increased funding levels in several key areas, negotiating a compromise with the Administration at one point to avoid the threat of a veto. The Association worked with the Congress to overcome efforts to reduce capitation support by those disenchanted with institutional funding. The AAMC's activities were closely coordinated with the Coalition for Health Funding. Although prospects seemed bright for enactment of the 1978 appropriation prior to the October 1 start of the fiscal year, House and Senate conferees reached an impasse in trying to resolve the language of their two very different anti-abortion amendments and a continuing resolution once again became necessary.

A set of administrative decisions by the federal government prompted additional activity for the Association. During 1976, through enactment of the Congressional Budget and Impoundment Control Act, the federal government transferred the starting date of its fiscal year from July 1 to October 1. This was accomplished by providing for a Transition Quarter in 1976 and by appropriating 25 percent in additional funds to cover this period. Unfortunately, no additional funds were provided for capitation grants. As a result, capitation funds from the 1976 appropriation represented a fifteen rather that a twelve month award. Although the Association made a vigorous attempt to secure a supplemental appropriation to fund the hiatus period, these efforts proved to be unsuccessful.

Initiatives by both the Congress and the Executive branch to regulate the activities of the private sector were of significant concern to the Association during the past year. Most notable among the regulations issued by the Executive branch to implement federal laws were the final DHEW regulations to promote non-discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance. These regulations, which implement Section 504 of the Rehabilitation Act of 1973, took effect in June and have far-reaching implications for all schools of medicine and teaching hospitals. Although the Association had responded to the proposed regulations both independently and jointly with the American Council on Education, many comments went unheeded. Preadmission inquiry into physical, mental, or emotional disabilities is now effectively prohibited and extensive and costly facility renovations may become necessary.

The Federal Trade Commission made two attempts to secure authority under which it would have been able to insert itself into the affairs of the medical schools and teaching hospitals. The Association, in concert with other organizations, has resisted both of these challenges. The first potential encroachment was averted when the DHEW Office of Education's Advisory Committee on Accreditation and Institutional Eligibility, charged by law with advising the Commissioner of Education on recognition of accrediting agencies, recommended that the Liaison Committee on Medical Education continue to be recognized as the official accrediting body for medical education. The LCME's status had been challenged before this Advisory Committee by the FTC, on the grounds that the involvement of the American Medical Association constituted a conflict of interest and

compromised the autonomy of the Liaison Committee. The FTC argued that the AMA, as a trade association, represented the economic interests of physicians and therefore had a vested interest in restricting the development and growth of new and existing schools of medicine. The LCME statement presented to the Committee demonstrated that the LCME had met the published criteria of the Office of Education and had operated effectively in the interests of quality without any hint of political interference for thirty-five years. The Association has also opposed any extension into the non-profit field of the FTC's statutory authority to regulate trade, arguing that the historic mission and economic orientation of that agency are unsuited to a field in which inter-institutional planning and coordination are vital.

A major development during 1977 was the introduction in Congress of two bills which would, for the first time, limit research activities either directly or indirectly. One, the Recombinant DNA Research Act, would place serious restraints on scientific inquiry in this very important research area. The second, the Clinical Laboratory Improvement Act, as originally introduced, would have added unnecessary barriers to the transfer of research-proven ideas to the care of patients. The Association took leadership to bring these potential research restraints to the attention of legislators and the scientific community and to work for their modification.

The Association has actively opposed legislation introduced in both the House and Senate to reverse a National Labor Relations Board decision that housestaff should not be recognized as employees covered by federal labor law. AAMC testimony emphasized that residency training is an integral part of the medical education process and that the resident's relationship with a hospital should be based on an educational, rather than an industrial, model. The testimony also discussed the development of contemporary graduate medical education and the effect that the legislation could have on the form and structure of graduate medical education.

The AAMC played a major role last year as the U.S. Supreme Court prepared to hear the case of *Regents of the University of California v. Bakke*. Called the most important civil rights case since the 1954 desegregation decisions, *Bakke* challenges the constitutionality of special minority admissions programs through which schools of higher education have admitted increased numbers of qualified minority students. The Association filed an *amicus curiae* brief in the Supreme Court, as it had previously done in the California Supreme Court, arguing that fair evaluation of applicants required schools to take race into account when evaluating other admissions criteria; that class diversity was an essential educational objective; and that integration of the profession and increased service to medically underserved minority communities were compelling state interests which could not be achieved by alternative means. The Association served as a national resource for the University attorneys and others filing briefs on studies concerning medical education and minorities in medicine. In addition, an AAMC study conducted last year was cited to the Court as authoritative proof that special admissions programs for the economically disadvantaged were not a rational alternative to special programs for minority applicants.

The Association welcomed efforts this year by the Carter Administration to reorganize and streamline the federal government. The Association commented upon and participated in the Administration's comprehensive review of the federal government's system of advisory committees, undertaken early in 1977, and in the reorganization project established by the President in June.

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 Association actively participated in a number of ongoing and new committees of the CCME. Major actions by the CCME included the final approval of a report of a joint CCME-LCGME Committee on the Financing of Graduate Medical Education and a tentatively positive response to a recommendation in a draft Government Accounting Office Report that the CCME assume responsibility for monitoring the specialty and geographic distribution of physicians and making recommendations to the HEW Secretary on actions which the government should take to influence these distributions. In the latter action, the CCME did not respond positvely to the further GAO recommendation that it assume regulatory responsibilities in this area. A number of new CCME committees were formed, including committees on future staffing of the CCME, on coordination of data on physicians, on finance, on the distribution of residencies by specialty, and on the creation of new and the expansion of existing schools of medicine.

The Liaison Committee on Medical Education continues to serve as the nationally recognized accrediting agency for 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. Survey teams are able to identify 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.

Continued recognition of the LCME by the Commissioner of Education was challenged this year by a staff arm of the Federal Trade Commission on the grounds that designation of committee members by the AMA created an inherent conflict of interest, compromised its autonomy, and made suspect its ability to conform to the requirements of due process. The LCME vigorously defended its structure and procedures and was awarded continued recognition for two years on the recommendation of the Commissioner's Advisory Committee. This action, however, carried with it a requirement for an interim report on LCME actions to alleviate identified concerns related primarily to the committee's relationship to the AMA and the AAMC. This matter will require the continuing attention of the Association over the next year.

The private sector recognizing authority, the Council on Postsecondary Accreditation, also evaluated the LCME and continued its recognition for a full term of four years.

During the 1976-77 academic year, the LCME conducted 46 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 found in the *AAMC Directory of American Medical Education*. During the past year, the LCME issued Letters of Reasonable Assurance for future accreditation for four new programs in medical education and granted provisional accreditation to two new medical schools. The LCME completed development of guidelines for the policy statement, "Functions and Structure of a Medical School," and supplemental guidelines for medical schools with branch campuses.

The Liaison Committee on Graduate Medical Education placed a special emphasis during the past year on improving communications with the twenty-three Residency Review Committees whose activities it now oversees. Significant misunderstandings had developed regarding the complementary role the LCGME and the RRCs play in the accreditation of programs in graduate medical education. Paramount among these was an apprehension by the RRCs that the LCGME was usurping their prerogative to evaluate the educational and scientific merits of the programs which they review. Through direct meetings with RRC chairmen, the role of the LCGME was clarified and the RRCs now appreciate that the LCGME review of their actions is carried out to ensure that there is sufficient documentation to sustain the RRC recommendations as to the accreditation status that is recommended following RRC review. Through meetings with the RRC chairmen, several areas of mutual concern regarding the accreditation process have been identified and efforts to improve accreditation through more effective staff support and closer interaction between RRCs and the LCGME are moving forward.

In July the LCGME received a draft revision of the General Requirements sections of the Essentials of Graduate Medical Education from its Subcommittee on Essentials. The draft is being widely circulated for comment prior to being approved by the LCGME and forwarded to the Coordinating Council on Medical Education for approval and transmittal to its five sponsoring organizations. Approval by the sponsors is required before the revised General Requirements are effective. The draft revision emphasizes the responsibilities of institutions which sponsor programs in graduate medical education, implementing a CCME Statement on Institutional Responsibility for Graduate Medical Education which was approved in 1974. It is anticipated that final approval of the General Requirements will occur in 1978.

The Liaison Committee on Continuing Medical Education decided to assume its official accrediting function in July 1977. At that time the LCCME will accredit organizations and institutions offering continuing medical education to practicing physicians on a national and regional basis. For national accreditation the LCCME will carry out both the surveys and the accreditation, while for the regional and local institutions the LCCME will receive for ratification recommendations from state committees and councils as a result of their local review process. For the immediate future, the LCCME has the tasks of establishing new criteria for accreditation, designing an accounting system for monitoring performance at the regional and local levels, and resolving financing and staffing.

The Coalition for Health Funding, which the Association helped form seven years ago, now has over 60 non-profit health related associations in its membership. A Coalition document analyzing the Administration's proposed health budget for fiscal year 1978 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 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.

As a member of the Board of Trustees, the Association maintains an active interest in the program of the Educational Commission for Foreign Medical Graduates and especially in its involvement in the implementation of provisions affecting foreign medical graduates contained in the Health Professions Education Assistance Act of 1976. The AAMC is advocating prompt implementation of these provisions through various channels including ECFMG.

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 organizations as well as others to respond to the academic intrusions of the health manpower law and on federal regulations broadly affecting higher education, such as those pertaining to affirmative action and the handicapped. The AAMC participates on an Interassociation Task Force on Equal Employment Opportunity staffed by the ACE.

Education

A variety of pressures, both internal and external, have brought about a clear emphasis on evaluation at national as well as local levels. Internal pressures have derived from the faculty's increasing concern about the effectiveness of their educational programs and of their roles in the educational process. Since many faculty have made more explicit their instructional objectives, they have found this accomplishment an important facilitating factor in more refined student and program evaluation. The time has also seemed appropriate for the review of educational innovations in curriculum structure and materials and in methods of assessing student performance. These interests have received reinforcement from society's demand for more explicit accountability both in terms of assuring that those who are certified by the educational community to deliver health care are the best available and in terms of assuring the students that their individual rights have not been compromised in the process.

Evidence of these thrusts has been manifested in the programs of the Association and its member organizations. Especially noteworthy have been the activities of the Group on Medical Education. A GME Technical Resource Panel submitted its final report on a "Protocol for the Follow-up of Graduates," offering suggestions to individual schools for systematically studying the relationship between educational and institutional variables and practice outcomes. The GME spring regional meetings devoted significant attention to evaluation. The Southern GME held a workshop on the need for monitoring the effort of the educationally disadvantaged together with mechanisms designed to enhance their progress. A plenary session in the Northeast Region focused on considerations for establishing a formal medical school unit to provide a wide variety of evaluation support to the educational process. The Western Region coordinated its meetings with those of the directors of such units and programmatically looked at ways to make continuing medical education efforts more effective. The Central Region dealt with the evaluation of instructor effectiveness, the assessment of student performance, and program review based on stated objectives. All of these themes are scheduled for renewed attention at the AAMC Annual Meeting.

The AAMC Ad Hoc Committee on Continuing Medical Education has worked closely with the GME at regional and national meetings in highlighting issues in continuing education that are of particular concern to medical schools and their faculties. As a result, the AAMC is now planning a research and development effort to explore means by which students in the continuum of medical education can learn to appreciate the importance of self-assessment and self-directed learning in maintaining and enhancing professional competence. The Ad Hoc Committee continues to engage AAMC constituents and other organizations in an effort to link more closely continuing education of physicians with their professional competence and performance.

A significant segment of the membership has contributed heavily to a Study of Three-Year Curricula in U.S. Medical Schools. The project staff is analyzing questionnaire responses from: (1) administrators, faculty, and students of medical schools that conducted three-year programs between 1970 and 1976; (2) deans of four-year schools; and (3) clinical program directors who evaluate graduates from three-year programs. Site visits at each of the schools participating in the study will complete the data collection phase of the project. A final report on the study is scheduled for completion in early 1978.

Heavy membership involvement in all phases of development and implementation has characterized the preparation of the New Medical College Admission Test. First administered in April 1977, the New MCAT provides six scores to students and to designated medical schools. Science knowledge and problems questions are combined and reported for each disciplinary area, giving scores in biology, chemistry, and physics. Problems are combined to yield one science problems score. Skills analysis tests yield one score each in reading and quantitative concepts. Sessions 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. Two publications have been prepared to provide extensive background information. One, for the prospective examinee, *The New MCAT Student Manual*, was first published in

1976. The second edition appeared this fall. It was expanded to include a four-hour illustrative test. The other publication, the *New Medical College Admission Test Interpretive Manual*, has been prepared to assist admissions committees and premedical advisers. It provides technical information relative to the use of test scores. The *Interpretive Manual* was distributed this summer. It is designed as a dynamic compendium to be updated at regular intervals. In this way, the most current information on the various applications of test data will be made available.

Working closely with the Committee on Admissions Assessment, staff have continued to pursue various strategies for the evaluation of personal characteristics. These noncognitive measurements are seen as necessary to broaden the basis for medical student selection and to document promotions decisions. Specific efforts have led to a project which involves explicating in observable terms relevant personal characteristics as they manifest themselves during the medical education process. Consensus on the precision and usefulness of such criteria will enhance performance evaluations and, as a result, will provide foci toward which predictive admissions instruments can be developed and tested.

The Biochemistry Special Achievement Test continues to be used for a variety of purposes by participating schools. These purposes include administering the test: (1) for advanced placement; (2) as a diagnostic tool to identify areas of weakness; (3) on an individual basis to test progress of self-paced students; and (4) as a final examination. It is revised and updated annually and is now in its eighth edition. Previous forms of the test are also available.

The AAMC Educational Materials Project continued collaboration with the National Library of Medicine in the development of quality control and information systems aimed at aiding the improvement of health professions education through educational methodology. One project relates to AVLINE, a computerized data base on nationally available multi-media educational materials in the health sciences. By means of a review system engaging over 1,000 health sciences experts, the AAMC assesses the majority of educational materials in the AVLINE data base and produces critical abstracts, which are accessible to the user as part of the AVLINE search. AVLINE now contains over 3,000 citations covering medicine, dentistry, and nursing—almost double the number reported a year ago. This audiovisual data base at the National Library of Medicine is expanding at the rate of approximately 100 items per month.

A related project is concerned with the need for extended sharing of computer-based educational materials. As a first step, the feasibility of appraising computer-based educational materials has been explored. In collaboration with some of the major program developers and users and in association with the Lister Hill National Center for Biomedical Communications, the AAMC conducted a pilot appraisal program. The possibility of establishing some quality standards of computer-based educational materials has now been ascertained, and the next step is to assess the interest among the producers and consumers in the development of such an appraisal system.

A 75% response rate was achieved in the 1976 follow-up of physicians who participated in the AAMC Longitudinal Study of Medical Students of the Class of 1960. The study, supported by a grant from the National Center for Health Services Research, is in the final stages of data analysis. A final report relating practice outcomes discovered in the recent follow-up to early personal, educational, and institutional variables is scheduled to be available at the end of this calendar year.

The AAMC responded to considerable interest among medical students and faculty in developing, over the past two years, an introductory course to international health in a self-instructional mode. Aided by a contract from the John E. Fogarty International Center of the National Institutes of Health, this international health course offers the student a cross-cultural and comparative approach to health problems. The course was tested last winter by approximately 200 medical students in 15 medical schools and is now available from the Springer Publishing Company.

Biomedical Research

The Association's major concern in the area of biomedical research during the past year has been in promoting means by which the funding of research and research training might be made more stable. The 1976 report of the President's Biomedical Research Panel, to which the AAMC contributed, was presented and discussed at the November meeting of the AAMC Assembly by Panel Chairman Franklin Murphy. A series of Congressional hearings on biomedical and behavioral research followed this report.

The Association actively supported a one-year extension of the legislative authorities for cancer research; for heart, lung, and blood research; for environmental research; and for research training in order to permit a more thorough review of the nation's effort. This extension was enacted and, during the respite thus afforded, the Association continued studies examining the status of the research endeavor in academic medical centers. The results indicated that, although the total amount of federal funds for research and research training in academic medical centers was maintained or increased slightly over the past decade, the proportion of the total budget of academic medical centers allocated for research declined sharply. This occurred because academic medical centers in recent years have engaged more heavily in education and patient care activities. The AAMC carried these findings to its constituents, to the Congress, and to the Executive branch during the past year.

For several years, the funding of biomedical research training has suffered from continuing pressure by the Office of Management and Budget to eliminate federal support. 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 trend, the Association collected information demonstrating the effects of cutbacks in research training funds and mobilized the interest of several organizations in seeking adequate funding levels. Because the perennial questioning of research training became increasingly severe, the AAMC has taken the leadership in coordinating a number of studies of research manpower. The AAMC has brought together various groups, including the Institute of Medicine and the National Institutes of Health, to define the data needed and to see that they are gathered and analyzed. Reports of problems in research training, especially in the clinical disciplines, led the AAMC to undertake a study of the status of such training at the request of the National Academy of Sciences Committee on Personnel Needs for Biomedical and Behavioral Research. The results of these studies provided data and recommendations for the Committee's 1977 recommendations to Congress and DHEW on the numbers and kinds of research personnel that need to be trained.

A study of the factors associated with the choice of careers in biomedical research was continued in 1977 with support from the National Institutes of Health. The career choices of the class of 1960 were examined to determine how the 500 members of this class who joined medical school faculties differed from their classmates who chose other careers. Patterns of research and graduate training of 15,000 basic science and clinical faculty were also explored in this study. In a related effort, a study was conducted on the impact of changes in federal programs on biomedical and behavioral research training in clinical disciplines. At the request of the clinical sciences panel of the Commission on Human Resources, National Academy of Sciences, the period 1972-1976 was studied.

The results of AAMC studies of biomedical research were also discussed by an AAMC study group appointed in September 1977 to assess the overall status of the biomedical research effort in academic medical centers, to review present Association policy, and to recommend any necessary policy changes. It is expected that the ultimate recommendations of this committee after review by the Executive Council will form the basis of AAMC efforts to secure more rational and stable federal support of the vital research function.

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 these activities, the public has become more aware of the negative effects on biomedical research of the Freedom of Information Act and the Federal Advisory Committee Act. Both the President's

Biomedical Research Panel and the Commission for the Protection of Human Subjects reviewed this problem and indicated that revisions of these "sunshine laws" are necessary to protect more adequately human subjects of research, the conduct of clinical research, and the intellectual property rights of individual researchers.

Government regulation of biomedical research was of particular interest to the Association as the Congress considered two bills that would place major restraints upon the scientific research community. Concern over the potential dangers to public health and the environment of recombinant DNA research produced a flurry of proposals which would have severely restricted the ability of scientists to conduct such research. The Association, along with other scientific organizations, was greatly distressed by the content of these bills and the haste with which the Congress acted upon them. The Association communicated to the Congress its conviction that it was inappropriate for the Congress to attempt to regulate research by statute except in the face of the clearest potential for danger, and attempted to demonstrate that the potential benefits of recombinant DNA research had been understated while the potential hazards had been overemphasized. The Association asked that the NIH guidelines on recombinant DNA research, which previously applied only to federally-financed research, be adopted as the formal regulations for all research in this area. The Association strongly opposed the establishment of a free-standing national commission charged with regulating this research.

The second potential restraint on research came in the form of legislation establishing detailed standards for clinical laboratories. While the AAMC recognized the legitimate concern over the quality and management of routine testing laboratories, the Association opposed the extension of this regulation to research laboratories. It was recommended that the HEW Secretary be authorized to develop more appropriate standards for laboratories combining both clinical and research functions in order to avoid inhibiting the transfer of research technology to patient care.

Health Care

New initiatives in primary care education have been taken by virtually all the nation's medical schools and teaching hospitals during the past decade. Almost universally, these initiatives have involved broader utilization of ambulatory care facilities for teaching, and in many instances they have resulted in major changes in affiliated residency programs. A survey conducted by the AAMC in 1973 demonstrated the nature of change which had occurred by that date. The data from that survey, published in the September 1974 issue of the *Journal of Medical Education* indicated that one half of the institutions had made major changes in primary care education during the preceding three years, that one-half of the institutions had programs for graduate level training in family medicine. What emerged from this analysis was a picture of primary care education in transition with as yet no clear pattern of optimum program development. In 1976, this survey was repeated using a modification of the original survey instrument in order to ascertain the magnitude of change which had occurred during the three year interval. The results will be published in the December 1977 issue of the *Journal of Medical Education*. By 1976, more schools were making an ambulatory experience a required part of the curriculum, 80 percent of the institutions had affiliated programs for graduate training in family medicine, and there had been a marked increase in the number of schools with affiliated graduate programs for the training of generalists in internal medicine and in pediatrics.

These changes have increased the demands for high quality ambulatory care training sites, particularly in university or affiliated teaching hospital out-patient clinics. For the past two years, the AAMC, supported by the Health Resources Administration, DHEW, has conducted a program consisting of workshops and on-site consultations to improve ambulatory services.

Institutional groups representing 27 of the nation's medical schools participated in this project over a 2-year period. The workshop portion of the project consisted of an intense planning, problem solving, and team building experience designed for top management of university affiliated teaching hospitals whose staff are interested in developing innovative ambulatory care delivery models, providing more efficient and accessible "one class" care, and improving educational experiences for medical students and house staff. During this process each institutional group worked closely with an inter-disciplinary faculty team experienced in ambulatory care oprations, organizational development and group process, and developed a time-specific action plan for initiating a change at its institution following the workshop program. A final program report is due early in 1978 and will summarize the collective experiences of the 27 participating institutions.

There is a national concern with developing effective measures to insure quality of care while at the same time containing the rapidly soaring overall costs of health care services. Physician self-evaluation and assessment of performance by peers is now generally accepted as an integral part of the health care process. It is postulated however, that the degree of physician compliance with, and the enthusiasm for, quality assurance programs may be directly related to the extent of appropriate experience with this subject received during the formative training years. Introducing these concepts into the curriculum is a complex matter involving many academic departments. While several academic medical centers are now interested in this concept, few have been successful in initiating large-scale programs. The AAMC has encouraged programs operated by students, under faculty supervision, to assist the quality of the patient care in which they are involved. In this way, students can gain a better appreciation and understanding of the need to develop a formal method of self appraisal. The AAMC has received support from the National Fund for Medical Education to conduct workshops on the subject in 1977-78. The initial workshop presented several models of inter-departmental curriculum design, a clarification of institutional prerequisites for successful program development, a strategy for curriculum phasing, and necessary resource allocations.

Faculty

During the year, the Association has conducted several programs aimed at assisting faculty development and promoting understanding of the ways in which decisions are reached for careers in biomedical research. A project in faculty development, with particular reference to teaching skills, was continued. In 1977, the data collection and analysis for the National Survey of Faculty were received from 1,910 medical school faculty members, out of a stratified random sample of 2,700, for a very satisfactory response rate of 71%. The basic findings from this survey have been presented in three preliminary reports which have been distributed to each medical school. The final report of this project, summarizing its highlights and major implications, will be distributed in December 1977.

The written simulations that were a major source of data for the National Survey will now be used as part of a voluntary, confidential, self-assessment program for faculty. During the past year, a pair of documents was developed to accompany each simulation. One provides a discussion of the rationale for the recommended routes through the simulations and an explanation of the basis for the other routes not being recommended. The other provides a general discussion of the topic area of the simulation, such as test construction, small group discussion, clinical supervision, and a list of suggested readings. These materials have been field-tested among faculty members at seven medical schools. The self-assessment packages will be ready for distribution in early 1978.

Beginning at the 1976 AAMC Annual Meeting, a series of four Workshops on Faculty Development was offered to medical school faculty members who have been identified by their deans as having responsibilities for contributing to the improvement of the instructional program at their institutions. A total of 155 faculty members from 82 different medical schools participated in these workshops.

Support for the National Survey, Self-Assessment Program, and Workshops have come from the Kellogg Foundation, the Commonwealth Fund, and the Bureau of Health Manpower.

The Faculty Roster System, initiated in 1965, continues to provide valuable information on the intellectual capital of medical education. This database maintains demographic, current appointment, employment history, and training/credentials information for all salaried faculty at U.S. medical schools. The data collection procedures include feedback to the schools providing the data in an organized and systematic manner that assists schools in activities that require faculty information, such as the completion of questionnaires for other organizations and the identification of alumni now serving on faculty at other schools.

This database has also been used for a variety of manpower studies, including a report released this year entitled *Descriptive Study of Salaried Medical School Faculty: 1969-70 and 1974-75*. This study was performed under contract with the Bureau of Health Manpower and contains summary information on faculty appointment characteristics, educational characteristics, employment history, and various breakdowns by sex, by race/ethnic group, for foreign medical graduates, and for newly-hired faculty. A companion study is underway containing 1976-77 data on salaried medical school faculty.

As of June 1977, the Faculty Roster contained information for 47,567 faculty, an increase of 6.4 percent over June 1976. An additional 25,788 records are maintained for "inactive" faculty, individuals who have held a faculty appointment during the past 12 years but do not currently hold one.

The 1976-77 *Report on Medical School Faculty Salaries* was released in December by the Association. Data on salaries by degree type were collected and reported for the first time since the beginning of the Survey. To insure comparability with prior years, data for faculty with all degrees combined are also included. This year's report presents data on 30,677 individuals, as compared to 30,487 in the 1975-76 report. The modest increase can be attributed to the elimination of affiliated faculty, house staff, and fellows from this year's reporting format.

Students

In the competition for 1977-78 first-year places in U.S. medical schools, more than 41,000 applicants submitted over 350,000 applications. This reflected, for the second consecutive year, a slight decline in the number of individuals seeking admission. Medical student enrollments, however, continue to rise, and the 15,613 freshmen and 57,765 total students reported by the nation's medical schools for 1976-77 represent an all-time high.

The application process was assisted again this year by the Early Decision Program as well as by the American Medical College Application Service (AMCAS). For the 1977-78 first-year class, 58 medical schools participated in the Early Decision Program, and 892 students were accepted. Since each of the 892 students filed only one application as opposed to the average of 8.9, the processing of about 7,047 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, matriculation, and enrollment. The AMCAS program continues to be guided in the development of its procedures and policies by the Group on Student Affairs Medical Student Information System Committee.

At the direction of the AAMC, the American College Testing Program continued responsibility for operations related to the registration, test administration, test scoring, and score reporting procedures for the Medical College Admission Test. Approximately 53,600 examinations were given in the spring and fall of 1976, down from 57,500 in 1975, and 58,200 in 1974.

April 30, 1977 marked the first use of the New Medical College Admission Test, when the test was administered to 30,648 individuals. The New MCAT represents an attempt to improve the assessment procedures for admissions and provides a more differentiated way for candidates to present evidence of their preparation for entering medical school. Beginning with the 1978-79 entering class, medical school admissions officers will require New MCAT scores as part of the application process.

Commissioned in 1976 to examine existing and potential mechanisms for providing financial assistance to medical students, the Task Force on Student Financing made an interim report to the Executive Council in June. In its report, the task force outlined long- and short-term recommendations and a proposal for a new guaranteed student loan program. The final report is expected in June 1978.

Also in the area of student financial assistance, the chairman of the Group on Student Affairs, members of the Task Force on Student Financing, and the GSA Committee on Financial Problems of Medical Students met with representatives of the White House Domestic Council to discuss the problems of financing medical students. The major concern stated was that rising costs and decreases in need-based financial assistance programs were combining to cause an upward trend in the income levels of enrolled medical students. Such a trend could seriously limit the opportunities for a medical education of the financially disadvantaged.

Several AAMC activities and publications have been aimed at increasing opportunities for minority students in medicine. Foremost among these has been the Simulated Minority Admissions Exercise (SMAE), first developed in 1974. The purpose of the SMAE is to train admissions committee members to assess the potential for medicine of minority applicants. To do this, the trainees review simulated applicant data which include grades, test scores, and noncognitive information. The SMAE has been offered to regional groups of admissions officers, advisers, and medical school admissions committees. Admission workshops have been conducted for over 20 schools.

Minority Student Opportunities in United States Medical Schools, published in 1975, was updated in July and distributed to admissions officers and advisors. This publication provides detailed information about medical school programs of recruitment, admissions, academic reinforcement, and financial aid available to disadvantaged students. The Medical Minority Applicant Registry has been compiled and circulated to all U.S. medical schools.

This registry is designed to assist the schools in identifying minority and financially disadvantaged candidates who are seeking admission to medical school.

Because of the increasing concern over the number of lawsuits being filed against schools charging that special minority admissions programs discriminate unlawfully against whites, the AAMC conducted a survey to determine the characteristics and outcomes of such suits. In the case of *Bakke v. Regents of the University of California*, the Association filed an *amicus curiae* brief before the California Supreme Court. The AAMC's position was that special admission programs for minority students do not violate constitutional equal protection safeguards. Continuing its support in the same case, the Association filed an *amicus curiae* brief before the U.S. Supreme Court asking for reversal of the California decision.

The AAMC Task Force on Minority Student Opportunities in Medicine was established to make recommendations to improve opportunities for minorities seeking careers in medicine. The 14-member Task Force presented an interim report to the Executive Council in September and should complete its final report in the coming year.

A major national program focusing on minorities in medical education is sponsored annually during the AAMC Annual Meeting. The program in San Francisco in 1976 featured U.S. Representative Yvonne Brathwaite Burke (D-California) who spoke on the contribution of minorities in medicine.

An action of the AAMC Executive Council, adopted last fall by the Group on Student Affairs, provides for a section within the GSA to include minority affairs representatives from every medical school in the country. The section will hold its first meeting this fall to discuss programs affecting admissions, financial aid, and the graduate education of minority medical students.

During the year, 11 major student studies were completed under contract with the Bureau of Health Manpower (BHM). Particularly notable was *The Medical School Admissions Process: A Review of the Literature, 1955-1976*, a comprehensive bibliography of almost 500 items.

Five of these reports dealt with medical student financing. *Medical Student Indebtedness and Career Plans, 1974-75* concluded that career choice was probably more closely related to student background than to indebtedness. *Student Finances and Personal Characteristics, 1974-75* revealed that nine in ten of those who applied for aid received some assistance. *Medical Student Finances and Institutional Characteristics, 1974-75* confirmed that students in private schools were more dependent on parental and outside aid than those in public schools. *A Study of Public Health Service (PHS) Scholarship Recipients and National Health Service Corps (NHSC) Participants* showed that the scholarship holders were somewhat more apt than medical students in general to be minority group members and to come from relatively lower socioeconomic backgrounds. A special report addressed itself to the topic, *Additional Selection Factors Suggested for the Public Health Service Scholarship Program*.

The other five projects dealt with the characteristics and career choices of recent applicants and students. The *Descriptive Study of Medical School Applicants, 1975-76* included an analysis of the 42 percent of applicants who were college seniors applying for the first time and showed their acceptance rate to be substantially higher than that for candidates in general. An analysis of *Economic and Racial Disadvantage As Reflected in Traditional Medical School Selection Factors* demonstrated that grade-point averages and MCAT scores of applicants varied only slightly by level of parental income within a given racial grouping, but varied far more substantially by race within a given income class. A study of *Characteristics of U.S. Citizens Seeking Transfer from Foreign to U.S. Medical Schools in 1975 via the Coordinated Transfer Application System (COTRANS)* confirmed that the majority had previously applied unsuccessfully to a U.S. school and that two thirds were from New York, New Jersey, and California. The *Descriptive Study of Enrolled Medical Students, 1975-76* included the finding that more first-year students than final-year students had preadmission career choices of general/primary care. A study of *Career Choices of the 1976 Graduates of U.S. Medical Schools* found that over half changed their specialty preferences from the time they took the Medical College Admission Test to the time they applied to the National Intern and Resident Matching Program. At graduation, almost two thirds preferred a primary care residency when defined to include internal medicine and pediatrics as well as family practice. Finally, a pilot study to ascertain the career aspirations and practice plans of graduates and the influence of their medical education was carried out at nine medical schools. This survey will be conducted nationally in 1977-78.

Other research initiated during 1976-77 included studies on 1976-77 applicants and enrolled students, a COTRANS trend study for 1970 through 1976, several additional studies of medical student financing, and a targeted study comparing the admissions process for 1976-77 and 1973-74.

Institutional Development

This past year represented the fifth year of the AAMC Management Advancement Program, which now includes three separate but related components: Executive Development Seminars (Phase I), Institutional Development Seminars (Phase II) and a Technical Assistance Program.

Phase I is an intensive six day workshop in management technique and theory. Lectures and discussion sessions provide an opportunity for medical school deans to share common problems while acquiring theoretical background knowledge in the general management area. Whenever possible, departmental chairmen and teaching hospital administrators are included as participants. Topics are drawn from a wide range of planning and control and behavioral science concepts.

Phase II, the Institutional Development Seminar, is a four and a half day session for which medical school deans who have participated in a Phase I session are invited to identify an institutional opportunity or problem requiring careful study. Each dean is asked to select a group of individuals from the medical school who would need to be involved in the implementation of any decision reached on the issue he has chosen to address. Five or six such institutional teams meet at an off-site location for lectures and team discussion sessions. Each team is assigned an expert management consultant who is responsible for facilitating group discussion during team sessions, and where appropriate, for suggesting alternative means of dealing with the self-identified management issue.

The Technical Assistance Program is designed to provide on-site management consultation to interested academic medical center administrators. The purpose of the program is to encourage improved organizational diagnosis, problem solving and/or planning. Site visit teams comprised of management consultants and experienced academic medical center administrators work with a limited number of medical school decision-makers who request the kind of assistance offered. Documentation of observations is an important part of the work.

Since its inception, the MAP has been both an educational effort and an opportunity for senior administrators from academic medical centers to develop institutional plans. All medical school deans are invited to attend. Since 1972, 102 deans, 41 hospital administrators and 27 department chairmen have participated in Executive Development sessions. Institutional Development Seminars have included 64 institutions of which 20 have attended more than one such follow-up session. Over 652 individual participants have attended; in addition to deans, department chairmen and hospital administrators, vice presidents, chancellors, program directors, business officers, planning coordinators, and state legislators have been included.

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. Support for early program planning was provided by the Carnegie Corporation of New York and by the Grant Foundation. Three grants from the Robert Wood Johnson Foundation have permitted full implementation of the program.

During the past five years, Management Advancement Program participants have expressed a growing and continuing interest in management issues facing their institutions. In addition, requests for seminars from a wide range of groups in the academic medical center environment have indicated the need to reach a broader audience. In order to develop a critical mass of individuals informed of current management theory and practices, the AAMC negotiated a contract with the National Library of Medicine, which began in the Spring of 1976 and was renewed for a second year in January, 1977. The Management Education Network Project is aimed at providing academic medical center administrators with regular access to management information. The project also includes documentation of the results of studies of institutional management problems and issues for wider dissemination. The contract encompasses the following specific tasks: 1) design of a management literature retrieval system, which includes the publication of "MAP Notes," a summary of current management information; 2) development of audiovisual instructional materials which will be avail-

able from the National Medical Audiovisual Center; 3) documentation of selected academic medical center managerial processes; and 4) exploration of the desirability and feasiblity of simulation modeling as a management tool for medical school decision-makers. Dr. J. Robert Buchanan has served as Chairman of the Advisory Committee, which has helped design and monitor program activities.

During the past year a detailed examination of the affiliation arrangements between a sample of six selected medical schools and their networks of affiliated teaching hospitals was completed. The Medical School-Clinical Affiliations Study, supported under contract with the Bureau of Health Manpower, follows a management perspective to examine the structure and process of decision-making in affiliation relationships. The project was completed 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 were analyzed to develop descriptions of the affiliation networks and to provide some assessment of what factors contribute to an effective relationship. Copies of the report were distributed to each member of the Council of Deans and the Council of Teaching Hospitals.

The Visiting Professor Emeritus Program, established in 1976, completed its first full year of operation during the past year. With support from the National Fund for Medical Education, this program serves as a link between emeritus faculty interested in continuing their careers on a limited basis and medical schools desiring to utilize the available talents of senior physicians and scientists. The response to the program has been most encouraging and greater utilization of this valuable reservoir of experienced medical educators promises to make a significant contribution to medical education.

Teaching Hospitals

Three major issues have dominated the Association's teaching hospital activities during the past year: Senator Talmadge's proposal to establish a prospective ceiling on payments for routine operating costs under the Medicare and Medicaid programs, the Carter Administration's proposal to place a ceiling on hospital revenue increases and to reduce hospital capital expenditures, and Congressional and legal challenges arising from the National Labor Relations Board's finding that housestaff are students for purposes of the National Labor Relations Act. Other issues receiving significant attention included the impact on major medical centers of the National Health Planning and Resources Development Act, the Association's court challenge of regulations implementing the routine service cost limitations of the Medicare program, and the anticipated implementation of legislation establishing fee-for-service payment requirements for physicians in teaching hospitals.

In early May Senator Herman Talmadge, Chairman of the Subcommittee on Health of the Senate Finance Committee, and twenty co-sponsors introduced a revised version of the Medicare and Medicaid Administrative and Reimbursement Reform Act. The bill was very similar to one introduced last year, including provisions to establish a payment limitation procedure for routine operating costs, to establish a special payment limitation category for the "primary affiliates of accredited medical schools," and to eliminate Medicare/Medicaid recognition of percentage contracts for certain physician services often performed in hospitals.

Association positions on the provisions of the Talmadge bill were initially re-evaluated by an ad hoc committee and subsequently adopted by the Association's Executive Council. In testifying on the bill before the Subcommittee on Health of the Senate Finance Committee, the Association acknowledged that hospital payment limitations derived from cross-classification schemes are one legitimate approach to containing expenditures for hospital services and recommended adding flexibility to the bill so that learning acquired through experience would not require new legislation. The AAMC recommended that the HEW Secretary initiate studies to define tertiary care/teaching hospitals and to examine the impact of establishing a special payment category for them. The Association strongly supported amending the bill to ensure that faculty physicians could be paid for either professional or educational services when providing care in the presence of students and opposed physician payment mechanisms which would inhibit the development of any discipline. Staff members of the Association have worked with Subcommittee staff to refine these proposed modifications.

In April President Carter introduced his Hospital Cost Containment Act of 1977, stating that "the cost of care is rising so rapidly it jeopardizes our health goals and our other important social objectives." The Association evaluated the Administration's proposal with the assistance of an ad hoc committee that included representatives from all constituent Councils. In House and Senate testimony on the cost containment proposal, the Association stated its strong opposition to both the imposition of a cap on hospital revenues when no other segment of the economy is similarly controlled and to a capital expenditure ceiling that fails to provide adequate funds for government-mandated facility improvements and for the replacement of obsolete facilities essential to patient care. In lieu of the President's proposal, the Association advocated a six-point cost containment program based on implementing a system of uniform hospital cost reporting, publishing hospital cost data, establishing a cost impact statement for hospital-related legislation and regulation, expanding and fully implementing utilization and health planning controls, enacting prospective payment limitations derived from cross-classification schemes, and permitting Medicare to pay state-determined hospital rates where the programs comply with necessary Federal standards.

In March of 1976, the National Labor Relations Board (NLRB) ruled in its *Cedars-Sinai* 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." In spite of this decision, some housestaff associations have pursued legal and legislative actions to have housestaff redefined as employees. In both state and federal

court actions, the Association has filed *amicus curiae* briefs supporting the NLRB decision and arguing that it pre-empts contradictory state labor board action. The U.S. Court of Appeals for the Second Circuit agreed with this position, preventing the New York State Labor Board from exercising jurisdiction over housestaff in hospitals subject to the federal labor law.

Bills specifically defining housestaff as employees under the National Labor Relations Act have been introduced in both the House of Representatives and Senate. The Association has reiterated in testimony its position that residency programs are an integral part of the medical education program, that residents' primary relationship with the hospital should be based on an educational rather than an industrial model, and that the imposition of a labor-management relationship would seriously reduce the effectiveness of these programs.

The National Health Planning Resources Development Act originally due to expire in 1977 was extended by Congress until 1978. Because the administration of the Act is principally based on local health planning agencies which may give inadequate consideration to the regional and national missions of medical schools and teaching hospitals, the Association contracted with Eugene Rubel, former Director of HEW's Bureau of Health Planning and Resources Development, to study the implementation of the Act. Based on recently completed site visits to several medical centers and health planning agencies, the study will provide the information necessary to evaluate how the Act is affecting the academic medical center.

The Association's appeal of its suit over HEW's implementation of Medicare routine service cost limitations is still pending before the U.S. Court of Appeals for the District of Columbia Circuit. While oral arguments on the appeal were presented in September 1976, the Court this past spring requested supplemental briefs on the jurisdictional authority of the courts in this matter. The Association filed the requested brief arguing that, while individual claimants seeking judicial review of specific benefit determinations must follow prescribed administrative procedures before turning to the courts, the court has direct and immediate jurisdiction to review agency regulations implementing legislation.

During the year, the Association worked closely with Executive agencies and COTH members in several areas where policies were being established or reviewed. These include uniform hospital accounting and reporting systems, Medicare offset requirements for family practice grants, Medicare's treatment of interest provisions of Section 227 of the 1972 Medicare amendments, and Medicare's recently enacted policy of recognizing self-insurance contributions as reimbursable malpractice costs.

The Associations' 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 publicly distributed. Three special surveys were conducted this year: the Survey of the Impact of Section 223, the Survey of Professional Liability Insurance in University-Owned Hospitals; and the Survey of Construction Funding for Non-Federal COTH Hospitals.

Communications

A variety of publications, news releases, news conferences and personal interviews with representatives of the news media are used by the Association to communicate its views, studies, and reports to its constituents, interested federal representatives, and the general public. The major vehicle used by the Association to inform its constituents is the President's *Weekly Activities Report*. This publication, which is issued 43 times a year and reaches about 9,000 readers, reports on AAMC activities and federal activities that have a direct effect on medical education, biomedical research, and health care.

In addition to the *Weekly Activities Report*, other newsletters of a more specialized nature are: *The Advisor, CAS Brief, COTH Report, DEMR Report* and *Student Affairs Reporter*. Numerous other publications such as directories, reports, papers, studies, proceedings, and archival listings are also produced and distributed by the Association.

In an effort to keep U.S. medical students abreast of national medical education issues, the Association has undertaken on a trial basis the publication of a newsletter distributed free-of-charge to the approximately 60,000 students. The two editions of *OSR Report* published to date have dealt with legislation, activities of the AAMC Organization of Student Representatives (OSR), and AAMC programs of special interest to medical students. The *Report* is mailed in bulk to each school's OSR representative in sufficient quantity for distribution to all medical students. Publication of the OSR *Bulletin Board*, which has been the AAMC newsletter for medical students for the past two years, has been temporarily suspended until after the Executive Council evaluates the effectiveness of *OSR Report*.

The *Journal of Medical Education* in fiscal 1977 published 1,166 pages of editorial material in the regular monthly issues, compared with 1,042 pages the previous year. One supplement was published during the year: "Analysis and Comment on the Report of the President's Biomedical Research Panel." In addition to the regular issues, a 104-page publication, *Federal Support of Biomedical Sciences: Development and Academic Impact*, by James A. Shannon, M.D., was carried as Part 2 of the July 1976 issue. The plenary addresses from the 1975 AAMC Annual Meeting and the 1976 AAMC Proceedings and Annual Report also were published in the *Journal*.

Excluding the supplement and the Part 2 publication, a total of 174 papers (82 regular articles, 81 Communications, and 11 Briefs) were published, compared with 152 papers in fiscal 1976. The *Journal* also continued to publish editorials, Datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1976-77 totaled 411, compared with 404 and 422 the previous two years. Of the 411 articles received in 1976-77, 141 were accepted for publication, 179 were rejected, 15 were withdrawn, and 76 were pending as the year ended.

Pages of paid advertisements totaled 81 during the fiscal year, compared with 92 pages the previous year. As the year ended, the *Journal's* monthly circulation was almost 6,800, an increase of 100 over a year ago.

About 30,000 copies of the annual *Medical School Admission Requirements*, 3,500 copies of the *AAMC Directory of American Medical Education*, and 6,000 copies of the *AAMC Curriculum Directory* were sold or distributed.

Information Systems

The Association has acquired a general purpose computer system to support its information requirements. Most information systems have become operational on the computer system since its installation in September 1976. This in-house system will allow the Association to optimize the use of its information resources in the programs of the Association.

The information system was utilized to generate several exploratory studies of medical schools in general, including: *Study of Medical Education: Interrelationships Between Component Variables; An Empirical Classification of U.S. Medical School by Institutional Dimensions;* and *A Multidimensional Model of Medical School Similarities.*

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: *Descriptive Study of Medical School Applicants, 1975-76, Descriptive Study of Enrolled Medical Students, 1975-76,* and a series of studies concerning the manner in which medical students finance their education, based on a previous AAMC survey of 1974-75 students. The series included *Medical Student Finances and Personal Characteristics, 1974-75,* and *Medical Student Finances and Institutional Characteristics, 1974-75.*

The Institutional Profile System contains over 12,000 data elements from more than 70 sources describing U.S. medical schools as institutions of higher education. The primary sources of data for the Institutional Profile System have been ad hoc and recurrent questionnaires administered by the AAMC and others, such as the Liaison Committee on Medical Education Annual Questionnaire Parts I and II. Data from other AAMC information systems, such as the Medical Student Information System and the Faculty Roster System, are also aggregated by institution and entered into the Institutional Profile System database.

The primary objective of the Institutional Profile System is the provision of a readily accessible repository of valid data that describe medical education institutions. This is accomplished through an on-line integrated database and supporting computer software package that allows immediate user retrieval of data via remote terminals. The system is used to respond to requests for data from medical schools (especially for comparative information) and other interested parties. Such requests numbered approximately 225 during the 12 months ending June 1977 and over 550 for the three years that IPS has been operational.

The Institutional Profile System has also been used extensively to support a variety of studies or projects that require institutional information. During the last year, several reports describing medical education institutions using multivarate statistical procedures were prepared under contract with the Bureau of Health Manpower, DHEW. The Institutional Profile System was also used to provide data to relate institutional characteristics to student finances and career choices.

The Association serves as the primary source of information on teaching hospitals. Annual surveys are conducted to obtain national information on housestaff stipends, benefits, and training agreements; income, expense and general operating data for university-owned hospitals; hospital and departmental executive compensation; and general operating, educational program, and service characteristics of teaching hospitals. Special studies conducted during the past year collected information on the impact on teaching hospitals of the routine service cost limitations imposed under the Medicare program and on the professional liability insurance coverage of and premiums paid by university-owned teaching hospitals. These surveys provided the necessary data for five general publications during the year: *1977 COTH Directory of Educational Programs and Services, 1976 COTH Survey of House Staff Policy and Related Issues, COTH Survey of University-Owned Teaching Hospitals' Financial and General Operating Data, 1976 Council of Teaching Hospitals Executive Salary Survey,* and *COTH Survey of Professional Liability Insurance in University-Owned Hospitals.*

Treasurer's Report

On August 31, 1977 the Association's Audit Committee met and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1977. Meeting with the Audit Committee were representatives of Ernst & Ernst, the Association's auditors; the Association's legal counsel; and Association staff. On September 16, 1977 the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $8,786,232—an increase of 1.37% from the previous fiscal year. Operating expenses increased 4.59% to $8,231,313.

Balances in funds restricted by the grantor decreased $135,348 to $153,498. After making provision for Board appropriations for special purposes in the amount of $299,000, unrestricted funds available for general purposes increased $463,419 to $5,364,571—a reserve equal to 65.17% of the 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% and, as a goal, 100% of the Association's annual operating budget. It is of increasing importance that this policy of reserve accumulation be continued. Approximately 30% of the Association's revenues are derived from sources outside of the Association. Because of the uncertainties associated with such funding, the existence of adequate reserves is needed to assure the continuation of essential services through transitional periods should there be substantial reductions in funding from outside sources. A Finance Committee appointed by the Executive Council is currently studying the financial structure of the Association with particular emphasis on future sources of funding.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
BALANCE SHEET
June 30, 1977

ASSETS

Cash		$ 185,958
Investments		
U.S. Treasury Bills	$5,283,907	
Certificates of Deposit	750,000	
Management Account	938,992	6,972,899
Accounts Receivable		819,158
Deposits & Prepaid Items		20,582
Equipment (Net of Depreciation)		435,803
TOTAL ASSETS		$8,434,400

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		$ 555,410
Deferred Income		1,014,453
Fund Balances		
Funds Restricted by Grantor for Special Purposes		153,499
General Funds		
Funds restricted for Plant Investment	$296,856	
Funds restricted by Board for Special Purposes	613,808	
Investment in Fixed Assets	435,803	
Available for General Purposes	5,364,571	6,711,038
TOTAL LIABILITIES & FUND BALANCES		$8,434,400

OPERATING STATEMENT
Fiscal Year Ended June 30, 1977

SOURCE OF FUNDS

Income	
Dues and Service Fees from Members	$1,591,725
Grants Restricted by Grantor	267,911
Cost Reimbursement Contracts	2,353,352
Special Services	3,557,202
Journal of Medical Education	69,658
Other Publications	367,377
Sundry	579,007
TOTAL INCOME	$8,786,232
Reserve for MCAT Development	167,364
Reserve for Special Minority Programs	50,848
Reserve for Special Legal Contingencies	28,338
Reserve for *Educational News*	41,000
Reserve for Data Processing Conversion	181,738
Reserve for Special Task Forces	38,668
Decrease in Restricted Fund Balances	135,347
TOTAL SOURCE OF FUNDS	$9,429,535

USE OF FUNDS

Operating Expenses	
Salaries and Wages	$3,841,127
Staff Benefits	502,855
Supplies & Services	3,260,893
Provision for Depreciation	37,970
Travel	588,468
TOTAL EXPENSES	$8,231,313
Invested in Fixed Assets	435,803
Transfer to Restricted Funds for Special Purposes	299,000
Increase in Funds Available for General Purposes	463,419
TOTAL USE OF FUNDS	$9,429,535

AAMC Membership

TYPE	1975-76	1976-77
Institutional	111	115
Provisional Institutional	6	3
Affiliate	17	17
Provisional Affiliate	0	0
Graduate Affiliate	1	1
Academic Societies	59	60
Teaching Hospitals	396	400
Individual	2,026	1,944
Distinguished Service	42	43
Emeritus	70	71
Contributing	7	6
Sustaining	17	12

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

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John M. Dennis
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Harlyn Halvorson
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Stephen Tarnoff
David Walthall

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James E. Eckenhoff
Ronald W. Estabrook

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AAMC MEMBERS:

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William D. Mayer
Jacob R. Suker

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AAMC MEMBERS:

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C. Duane Gaither
Philip Gillette
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David C. House
Jerry Huddleston
Warren Kennedy
V. Wayne Kennedy
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Michael Mattsson
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A. Geno Andreatta
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Paul R. Elliott
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Henry H. Hoffman
Martin A. Pops
Thomas A. Rado
W. Albert Sullivan

HOSPITAL COST CONTROL

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