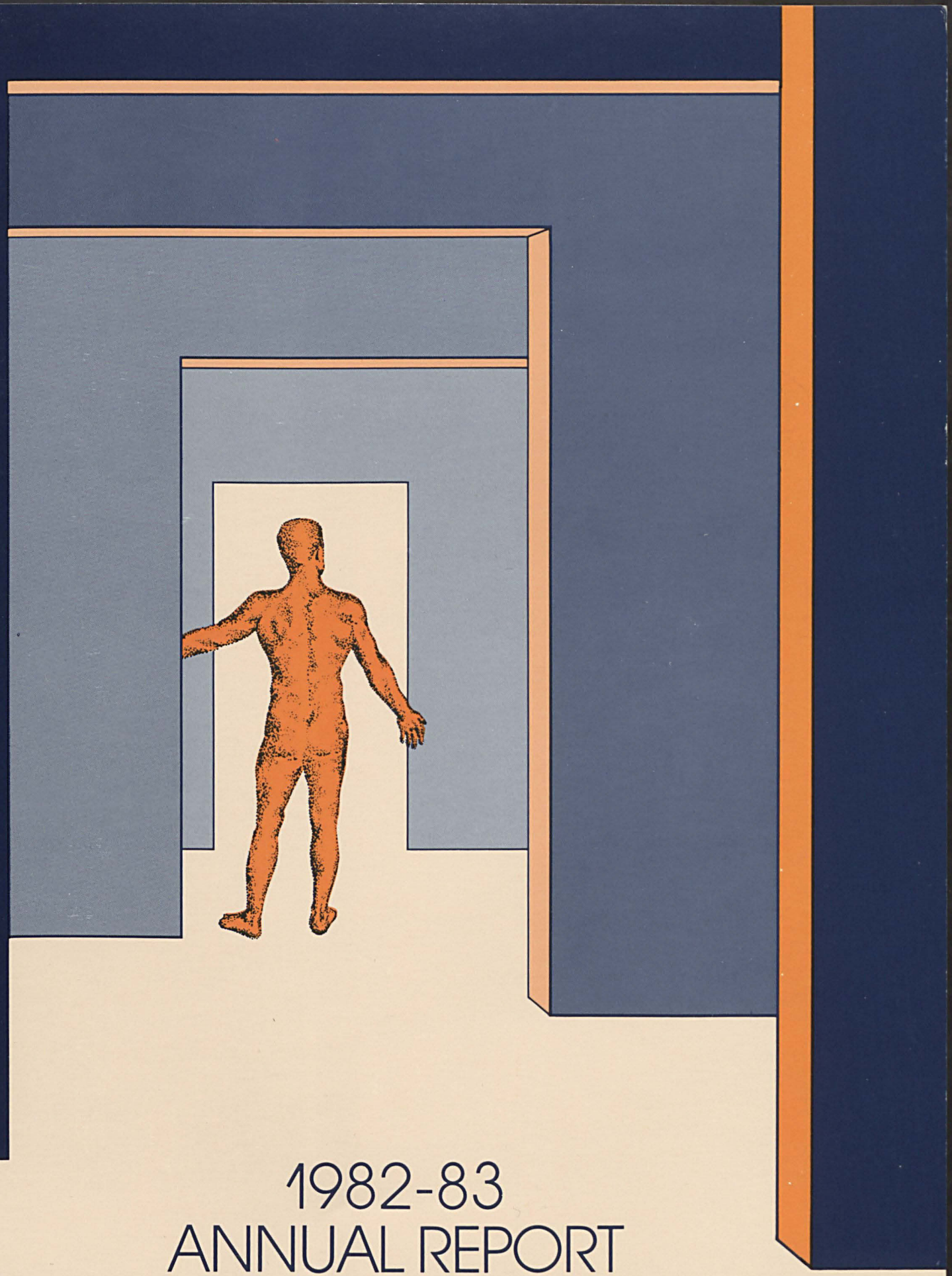

1982-83 ANNUAL REPORT

Association of American Medical Colleges

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1982–83 ANNUAL REPORT

Association of American Medical Colleges
One Dupont Circle
Suite 200
Washington, D.C. 20036

CONTENTS

President's Message

In his book, *Self Renewal,* John Gardner observes that "there is a stage in the life of a society (or organization or movement) in which the innovators and creative minds flower and a stage in which the connoisseurs and critics flower." Creative minds and innovative individuals have developed an outstanding system of American medical education, one recognized as preeminent in the world. However, there are now indications that our academic medical centers are moving into the second stage of Gardner's process. Without a resurgence of innovation and renewal through the activities and contributions of creative individuals, there will be deterioration and decay in these institutions.

To maintain the excellence of our programs for the preparation of physicians, we must break through rigidity, tradition and complacency to renew and refresh our concepts of medical education. The challenges posed by the rate of accumulation of biomedical knowledge, the changing environment of medical education, and the incorporation of new technology and practice modes in medicine require a shift of emphasis in the education of students. Unfortunately, under the present system, the growing density of the trees is making it more and more difficult for students to see, understand and appreciate the forest.

The focus should be on mastering general concepts in the sciences underlying medicine and developing the ability to actively acquire knowledge, rather than on learning large numbers of facts soon superseded by new information.

There should be more stress on students learning the skills of acquiring knowledge and selecting what to learn. Time must be available for the student to do this and faculty must provide guidance. Many students come to medical school without these important skills which provide the basis for continuing learning after the formal period of medical education. There should be a concurrent change in the methods of evaluating students compatible with this different philosophy of education.

Changes in medicine over the past two decades mandate a reexamination of the methods used in the clinical training of medical students in the traditional clerkship program. Since almost all medical school graduates continue their clinical training in residency programs, medical schools no longer prepare their graduates to practice medicine with only one year of internship. Now the role of the medical school is to provide students with a general professional education to prepare them for graduate medical education. Providing this general professional education is becoming more difficult as increased specialization in medicine is reflected in the interests of the clinical faculties and the organization of clinical services in the teaching hospital. Instead of a broad introduction to the fundamentals of clinical medicine, the medical student often encounters an uncoordinated series of experiences in specialty and subspecialty medicine. Furthermore, the demands made by the complex care provided in the teaching hospitals may compromise the time students have for study and other kinds of learning during their clerkship. The greater involvement of the full-time clinical faculty in obtaining income for the medical practice plan may also reduce their interest and availability for close teaching relationships with the students. Innovative and creative approaches to these problems are required to provide an appropriate education for medical students in this environment.

The selection, promotion and rewards of the faculty are more heavily based on research productivity than on their interest and abilities in teaching. The situation results, in part, from the difficulty in objectively measuring excellence in teaching. Evaluation is also complicated by the different settings in which good teaching can occur—in the large classroom, in small groups, at the bedside, or in the laboratory. Not all faculty members teach equally well in all settings. High priority should be given to assign the faculty to the teaching setting in which they are most effective and to develop ways to evaluate teaching and reward excellence.

The rise of connoisseurs and critics has begun to sap the vitality of the nation's research effort. The great freedom and flexibility of the biomedical enterprise established after World War II as a cooperative venture of private sector researchers and the federal government is coming under attack by individuals who do not understand the untidiness of research and the ambience required for creative investigation to blossom. The Congress and non-scientists in the executive branch are attempting to replace the judgment of working investigators on the most promising fields to support and the organization of research with their views based on inappropriate criteria.

If the United States is to continue its leadership role in biomedical research, there must be a change in the behavior of the Congress and special interest groups. The Congress must carefully weigh the importunings of special interest groups that believe they can achieve special advantages by having directives incorporated into legislation for set-asides of funds for their research interests. In the current situation of restricted total appropriations for the NIH, this action can only deprive other, often more meritorious, proposals of support. There is ample evidence that the NIH does respond in responsible ways to societal interests and scientific opportunities long before congressional action can have any effect. When large numbers of special interest groups succeed in incorporating their wishes into legislation, the rigidity in the NIH program increases and the most effective use of public funds is compromised.

Our science policy should be based on the recommendations in the 1945 report to President Truman by Vannevar Bush in *Science, the Endless Frontier.* Bush identified the dominant need for continuing the important contributions that science had made to the nation in World War II as federal support, essentially free from federal interference, for "basic research" upon which the nation's industrial development would depend. The recodification of the Public Health Service Act in 1944 gave the executive branch of the federal government the broad latitude and flexibility recommended by Bush. During the 1950s and early 1960s, a group of enlightened legislators, which included Senator Lister Hill of Alabama, Congressman John Fogarty of Rhode Island and Melvin Laird of Wisconsin, recognized that those most competent to decide priorities for biomedical research funding were working scientists participating in a peer review process and that the administering agency was best suited to determine the specific organizational form most effective in implementing the program. Influential members of the Congress are attempting to move federal policy away from these wise insights on the factors that have made our biomedical research the envy of the world.

Changes in the methods of reimbursing medical care also impact on the academic medical center. The high costs of the complex care provided by teaching hospitals make them particularly vulnerable to changes based primarily on the wish to reduce money flowing into the medical care system. The move away from reimbursement of costs incurred in providing care to prospective pricing for the treatment of an illness will require new levels of cooperation between the clinical faculty, housestaff and medical students, and the administration of the hospital. The survival of the hospital requires that patient care be provided within the limits of reimbursement available. The length of stay and use of ancillary services are critical components in maintaining fiscal viability. The limitations being imposed on hospital care and the threat to move to prospective pricing for physician services will have serious effects on the income earned by the clinical faculty, a major source of support for medical schools.

Gardner points out that there is no shortage of new ideas to revitalize a society or an organization. "The problem is to get a hearing for them. And that means breaking through the crusty rigidity and stubborn complacency of the status quo," and the "mind-forged manacles" used as the defenses against new ideas.

The current multiple assaults against the academic medical centers and their programs may be the "shock treatment often required to bring about renewal."

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

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The Councils

EXECUTIVE COUNCIL

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

The traditional December retreat for newly elected officers and senior staff of the Association provided an opportunity to review a number of the Association's major ongoing activities and to develop priorities for the coming years. Final revisions were made in "Strategies for the Future: An AAMC Workplan," initially conceived and developed at the 1981 officers' retreat. The current status and future plans of the AAMC's General Professional Education of the Physician and College Preparation for Medicine project were reviewed prior to the project's beginning its series of regional hearings on undergraduate medical education. Possible AAMC activities for a national medical research awareness project, for new constituent services, and for participation in the American Medical Association's Health Policy Agenda project were considered. There was also discussion of expected legislative and regulatory actions, with particular attention given to Medicare reimbursement issues. Other agenda topics included the study of trends in medical school applicants and matriculants and the appropriate role for the Association in manpower forecasting.

Many of the issues reviewed and debated by the Executive Council during the past year were concerned with the interface between the federal government and the educational, research and patient care missions of AAMC constituents.

Particular attention was given to reimbursement issues since major changes in Medicare policies were incorporated in the Tax Equity and Fiscal Responsibility Act and in the Prospective Payment System for Medicare. Early in the year the Executive Council adopted nine criteria as essential in any prospective payment plan. These included recognizing the impact of the hospital's scope of services, patient mix and intensity of care in operating costs, and recognizing the costs associated with manpower education, clinical research, and the use of new diagnostic and treatment technologies.

The Executive Council also reviewed a proposal to establish a Physician's Advisory Commission on Clinical Practice to examine major differences in medical practice and their contributions to variances in length of stay. In another action the Council identified certain issues in calculating a hospital's resident-to-bed ratio, and requested that they be brought to the attention of the Health Care Financing Administration prior to the implementation of the prospective payment system.

A number of concerns were expressed with Department of Health and Human Services regulation on "Nondiscrimination on the Basis of Handicap," which related to the provision of appropriate medical treatment to severely handicapped infants. The Council opposed the regulation as too broad an interpretation of 1973 legislation, and because it specified an ill-conceived method of obtaining information and inappropriately injected the government in medical decision-making.

Since federal research funding had not enjoyed any real growth in the past several years, a number of proposals had surfaced to "stretch" such funds by reducing the amount of money awarded to approved applicants with the highest priority scores and distributing the amounts thereby recovered among approved applications with lower scores. The Council strongly endorsed the current system for research funding, believing that the sliding scale would endanger the future funding of biomedical and behavioral research.

The reimbursement of indirect costs for research supported by the National Institutes of Health continued to occupy the attention of the Association. The NIH had drafted a proposal for controlling indirect costs under which each institution's level of indirect costs would be tailored to its own historical experience. The Executive Council added its support to a request by other higher education associations that DHHS examine whether existing criteria for determining allowable costs of research

were appropriate and whether methods of apportioning costs among university functions and research projects were fair.

In response to the expiration of the authority for the President's Commission for the Study of Ethics in Medicine and Biomedical and Behavioral Research, the Executive Council expressed support for the continued study of ethics in medicine through an established body such as the National Academy of Sciences. The Council also worked on a proposal under which the educational loans of physicians choosing careers in academic research would be forgiven.

Various legislative proposals relating to the National Institutes of Health were reviewed by the members of the Executive Council who were distressed by the level of "micromanagement" evidenced in these bills. The Council elucidated a set of principles in support of a strong biomedical research effort which it endorsed as the basis for any legislation in this area.

A series of court actions related to the Medical College Admission Test required oversight by the Council, which also considered ways to strengthen and improve the examination. Two projects were approved, one to add an essay question and another to establish a diagnostic services program that would provide a detailed assessment of strengths and weaknesses of students in the areas of academic preparation tested by the exam.

Questions relating to the match for second-year postgraduate positions led the Council to request a staff review of current policies and problems with the thought that refinements could improve the match program in this area.

A report from the Association of Minority Health Professions Schools was reviewed, and the Executive Council was pleased to note that it had anticipated many of that body's recommendations in its own 1978 task force report.

As a parent or founding member of other organizations, the Association must occasionally review and approve policy decisions by these organizations. The Executive Council ratified a policy statement of the Accreditation Council for Graduate Medical Education relating to criteria for entry into graduate medical education programs by graduates of schools not approved by the Liaison Committee on Medical Education or the American Osteopathic Association. The Council also endorsed an elaboration of transitional year special requirements.

The Accreditation Council for Continuing Medical Education presented guidelines to accompany the Essentials of the ACCME; these were approved by the Council. The Council was also asked to act on the ACCME protocol for recognizing state medical societies as accreditors of local continuing medical education courses. The Executive Council made several suggestions for revision in the protocol to assure that the ACCME would retain accountability in this process. Although modifications were made to allow additional input into the process by ACCME representatives, the Executive Council remained dissatisfied with the degree to which the ACCME would maintain oversight and provide a national accreditation standard.

The Educational Commission for Foreign Medical Graduates asked the Association, as a founding member, to comment on proposed bylaw changes being considered by that organization. Although some of the changes presented no problem, the Council was especially concerned that proposals to increase the number of public members and to alter the process by which representatives were nominated to the Board of Trustees would further distance the ECFMG from its sponsoring organizations.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees. A report from the Committee for Payment of Physician Services in Teaching Hospitals, chaired by Hiram C. Polk, chairman of surgery, University of Louisville School of Medicine, was presented and approved for distribution so that its findings could be considered as HCFA developed and implemented special payment rules for services in a teaching setting.

The final report of the Steering Committee for the Regional Institutes on Geriatrics and Medical Education project was also approved by the Executive Council. Joseph E. Johnson, III, chairman of internal medicine, Bowman Gray School of Medicine, presented "Undergraduate Medical Education Preparation for Improved Geriatric Care: A Guideline for Curriculum Assessment," which outlined ways for medical schools to enhance their teaching of geriatrics and gerontology.

The Council also approved the recommendations of an ad hoc committee chaired by Edward Stemmler, dean, University of Pennsylvania School of Medicine. The committee, which had been charged with reviewing the Association's management education programs, recommended that the continuing administrative education of its members be a primary mission of the AAMC and that new educational efforts be planned and initiated. The implementation of these recommendations was seen in the successful series of regional seminars held on "Medicare Prospective Payment System: Implications for Medical Schools and Faculties."

During the course of the year the Executive Council also reviewed the activities of the advisory panel and working groups for the General Professional Education of the Physician project.

The Executive Council continued to oversee the activities of the Group on Business Affairs, the

Group on Institutional Planning, the Group on Medical Eduation, the Group on Public Affairs, and the Group on Student Affairs.

The Executive Council, along with the Secretary-Treasurer, Executive Committee, and the Audit Committee, exercised careful scrutiny over the Association's fiscal affairs and approved a modest expansion in the general funds budget for fiscal year 1984.

The Executive Committee met prior to each Executive Council meeting and conducted business by conference call as necessary. During the year the Executive Committee met with HHS Secretary Margaret Heckler, Congressman Albert Gore, Betty Pickett, director, Division of Research Resources, National Institutes of Health, and Senator Lowell Weicker. They also met twice with the Executive Committee of the Association of Academic Health Centers to discuss issues of mutual concern.

COUNCIL OF DEANS

The activities of the Council of Deans in 1982-83 centered on business meetings and program sessions conducted in conjunction with the Association's annual meeting in Washington, D.C. and at the Council's spring meeting in Scottsdale, Arizona. During the intervening periods the Council's Administrative Board met quarterly to deliberate Executive Council items of significance to the Association's institutional membership and to carry on the business of the Council of Deans. More specific concerns were reviewed by sections of deans brought together by common interest.

The annual business meeting consisted mainly of a series of discussions on recently completed work products, planned activities, and current issues. The work products included a summary of issues and proposed actions of the AAMC relating to the evaluation of the clinical performance of clerks and the report, "Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management." The COD presentation was a prelude to an annual meeting panel discussion entitled, "Academic Medical Centers Confront the Information Age." Key among the current issues portion was a review of the new Medicare program regulations with particular attention to the three sets of regulations of primary interest to the members of the Council: payment of fees for assistants at surgery, the limitation on reasonable charges for services in hospital outpatient settings, and hospital based physician regulations. The Council unanimously supported the principle that the disposition or use of a fee should not alter the amount of a Medicare fee, opposed that portion of the regulatory proposal which would mandate compensation-based fees for physicians paid on a salary basis, and opposed the implementation until proposed regulations on payment for physicians' services in teaching hospitals were also published with an appropriate comment period. Additional discussions focused on the proposed medical research awareness project and the plan developed by the Group on Student Affairs to promote adherence to the National Resident Matching Program agreements.

Ninety-eight deans attended the annual spring meeting April 6-9th. Kenneth W. Clarkson, associate director for Human Resources, Veterans and Labor, Office of Management and Budget, began the first program session with an overview of President Reagan's FY 1984 budget and described the administration's rationale for health-related expenditures. Major General Garrison Rapmund, commander, U.S. Army Medical Research and Development Command, and Robert Newburgh, leader of biological sciences, Office of Naval Research, presented reviews of their health research programs and discussed areas of current priority for extramural funding. Donald Young, deputy director, Bureau of Program Policy, Health Care Financing Administration, and Truman Esmond, president, Health Charge, Inc., discussed recent changes in Medicare physician reimbursement policies and the implications of forthcoming prospective pricing for hospitals. Raja Khuri, dean, American University of Beirut, provided an historical prospective on the role of the AUB medical center during the recent military crisis in Lebanon, noting its significant medical and humanitarian contributions. Alfred E. Gellhorm, director emeritus, Sophie Davis School of Biomedical Education, City College of New York, described the seven Interface Experiments sponsored by the Commonwealth Foundation. Dr. Gellhorn highlighted the programs at three universities and their attempts to implement early admission options to medical school, and the programmatic initiatives undertaken to integrate the natural and behavioral sciences with the basic sciences. Donald Drake, a science writer for the *The Philadelphia Inquirer,* provided a unique perspective on medical education through his personal experiences while living as a medical student with the class of 1978 at the University of Pennsylvania. The program concluded with an open forum on the AAMC's General Professional Education of the Physician Project, with chairman Steven Muller, co-chairman William Gerberding, panel members John Gronvall, Daniel Tosteson, David Sabiston, Victor Neufeld, and project director August Swanson.

The spring meeting was preceded with an orientation session for new deans introducing them to the AAMC leadership and staff, followed by a briefing on the resources and programs of the

AAMC. During the spring business meeting, the Council reviewed topics relating to the Medical College Admission Test, the Regional Institutes on Geriatrics and Medical Education, trends in the National Resident Matching Program, applicant and matriculant trends, and an overview of current legislative activities in medicine.

Sections of the Council that met during the year were the Southern and Midwest deans and the deans of New and Developing Community-Based Medical Schools. The deans of private-freestanding schools convened a special meeting session at the COD Spring Meeting.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies is comprised of 73 academic societies representing U.S. medical school faculty members and others from the basic and clinical science disciplines. Two major meetings of the CAS were convened in 1982-83.

The 1982 CAS annual meeting in November focused on the AAMC's General Professional Education of the Physician project. In a joint program with the Organization of Student Representatives, students and faculty discussed the GPEP working group topics: fundamental skills, essential knowledge, and personal qualities, values and attitudes that should comprise the education of the physician. Stanley J. Reiser, professor of humanities and technology in medicine, University of Texas Health Sciences Center, spoke on "The Enigmatic Future and Tumultuous Past of Medical Education." He emphasized the rapid expansion of biomedical knowledge and the application of technological advances, pointing out the complex ethical dilemmas they may place on today's physicians.

"The Effects of Changing Federal Policies in Academic Medical Centers: Implications for Biomedical Research," was the theme of the 1983 CAS Interim Meeting. Key congressional staff and executive branch officials attended a plenary session and participated in small group discussions with CAS representatives. The plenary session began with National Institutes of Health Director James B. Wyngaarden who discussed program and policy directions of the NIH. The importance of supporting investigator-initiated research and the training of future investigators was emphasized. Theodore Cooper, executive vice president of Upjohn Company, spoke on political control and its effects on federal sponsorship of biomedical and behavioral research. He emphasized that decisions to support research in any area should be based on scientific merit and the opportunities available for discovery and advancement of knowledge. Julius R. Krevans, chancellor at the University of California, San Francisco, discussed the partnership which evolved between the federal government and academic medical centers since the 1950s and the destabilizing effect of recent federal policy changes regarding the support of research, medical education and patient care. Gerald S. Levey, chairman of medicine at the University of Pittsburgh, discussed proposed animal research legislation, one example of how changing policy could adversely affect medical schools.

Another session of the meeting considered geriatrics and medical education. AAMC Vice President John F. Sherman reported on "Undergraduate Medical Education Preparation for Improved Geriatric Care: A Guideline for Curriculum Assessment." The document, prepared by an AAMC steering committee, reflected discussions held at four regional institutes in 1982. Dr. John Rowe, director of the division on aging at Harvard Medical School, discussed future directions for academic geriatrics.

The CAS Administrative Board conducted business at quarterly meetings held prior to each Executive Council meeting. At its January meeting, the CAS and Council of Deans Administrative Boards met with H. George Mandel, chairman of pharmacology at George Washington University, and William F. Raub, associate director for extramural research and training at NIH, to discuss the implications of a number of proposals to stretch research funding. Leonard Heller, Robert Wood Johnson Health Policy Fellow working with Representative Edward Madigan, joined the April meeting for an informal discussion of the role of the academic community in federal policy making. In June special attention was given to the NIH peer review system and the work of study sections. William F. Raub, Thomas E. Malone, NIH deputy director, and Stephen Schiafino, deputy director of the NIH Division of Research Grants, were present to answer questions and discuss the Board's concerns.

The changing pace and complexity of legislative activity stimulated concern about whether the quarterly *CAS Brief* could provide adequate information to member societies in a timely manner. The Administrative Board decided to discontinue publication of the *Brief* and, instead, encourage member societies to subscribe to the AAMC *Weekly Activities Report.* The Association's CAS Services Program continued to assist societies desiring special legislative tracking and office management services. Six societies participated in the program in 1982–83: American Federation for Clinical Research, Association of Professors of Medicine, American Academy of Neurology, American Neurological Association, Association of University Professors of Neurology and Child Neurology Society.

COUNCIL OF TEACHING HOSPITALS

Two general membership meetings highlighted the activities of the Council of Teaching Hospitals during 1982-83. "Health Care Coalitions: Trustees in a New Role or Business As Usual?" was the theme of the COTH general session at the AAMC annual meeting. The featured speakers were Irving W. Rabb, vice chairman of the board and director of the Stop & Shop Companies, Inc., and Willis Goldbeck, director of the Washington Business Group on Health.

Mr. Goldbeck, whose organization represents approximately 200 of the nation's major business corporations, has assisted corporations in responding to rapidly rising health costs. He asserted that business leaders are increasingly concerned about the cost and manner in which health care is delivered and aware of the need to exert their influence in this arena. Goldbeck cited examples in which business coalitions are monitoring hospital utilization and introducing increased competition into the health care market. He invited a coalition from the academic medical community to meet with business representatives to address the future financing of medical education.

Following Mr. Goldbeck, Mr. Rabb explained the problems he faced as both a hospital trustee and a major employer. He advised hospital executives to educate policy-makers and businessmen on the nature of teaching hospitals and the reasons for the differences between teaching hospitals and community hospitals. He said, "Only if business is convinced that you are running an efficient operation, engendering prudent utilization, and working for prudent cost behavior in both scholarship and service, will we be recruited to work with you to preserve this extraordinary capacity which you have developed in American academic medicine."

The sixth annual spring meeting of the Council of Teaching Hospitals was held in New Orleans, Louisiana, May 12 and 13. The main topic of discussion for the more than 200 teaching hospital executives in attendance was state and local initiatives in hospital cost containment. William Guy, Medi-Cal negotiator for California, described the California one-year experiment in which hospitals bid on contracts to treat Medicaid patients. Under this highly controversial program some hospitals traditionally providing service to a large proportion of Medi-Cal patients failed to receive contracts. Guy found the real issue of concern to be the financial accountability of hospitals and suggested the hospitals' ability to unilaterally determine the cost and charges for inpatient care would soon disappear. Guy was followed by Paul Ward, president of the California Hospital Association, and William Gurtner, executive vice president of Mount Zion Hospital and Medical Center in San Francisco. In responding to Guy's remarks, Ward indicated that he felt the contracting process was a temporary approach and predicted that attention would be diverted from the issue of cost to denial of care. Gurtner told his colleagues of the reaction when his hospital, a substantial provider of Medi-Cal services prior to the contracting, was denied a contract. Gurtner specified the three areas of concern in implementing such a negotiation process: the skimming of the healthier patients by some hospitals; teaching costs, which payers and government bodies perceived to be someone else's responsibility; and a simplistic approach to competition and contracting that failed to recognize appropriate differences among hospitals and the type of services provided.

Other state and local plans discussed during the spring meeting included a description of the "managed care" approach taken by the Commonwealth Health Care Corporation in Boston, Massachusetts, described by Rena K. Spence, its executive director; the Rochester, New York area cost containment approach of developing caps on hospital revenues, explained by Gennaro Vasile, executive director of Strong Memorial Hospital; North Carolina's recent limitations on the days of care allowed Medicaid patients receiving certain types of care, described by Eric Munson, executive director of North Carolina Memorial Hospital; the Arizona Health Care Cost Containment System, that state's first Medicaid program, outlined by David A. Reed, president of Samaritan Health Services; and a teaching hospital experience in establishing a preferred-provider organization in response to competitive pressures, discussed by Gary Brukardt, vice president of affiliated corporations of Presbyterian-St. Luke's Health Care Corporation.

John M. Eisenberg, chief of general medicine at the Hospital of the University of Pennsylvania, Richard Gaintner, president and chief executive officer of the Albany Medical Center, and Warren Nestler, vice president of Overlook Hospital in Summit, New Jersey explained various approaches to managing the delivery of care. Eisenberg discussed modification of physicians' behavior to promote cost containment. Gaintner described the decentralized approach to management used at The Johns Hopkins Hospital, and Nestler told of the use of DRG information to compare physician performance in delivering care to various types of patients. The audience also heard from Richard Thompkins, a manager at Arthur Young and Company, on his firm's study of the cost of graduate medical education, which is currently being conducted for the Department of Health and Human Services.

The spring meeting attendees also heard from Carl Eisdorfer, president of Montefiore Hospital

and Medical Centers in New York and John Sherman, vice president of the Association of American Medical Colleges, on the need for increased attention to geriatric medicine and the education of future practitioners to meet the needs of geriatric patients.

The Council of Teaching Hospitals Administrative Board met five times during the year. Its discussions dwelt on payment for hospital services and payment for physician services, both of which were changed dramatically by federal law and regulation during 1982–83. The Board considered how to make policy-makers more aware of the functions and needs of the teaching hospital and how to protect the physician practice plans in teaching hospitals. As part of its overall attention to reimbursement issues, the Board reviewed proposals for prospective payment systems for hospitals made by the American Hospital Association and the Department of Health and Human Services, and reviewed and advocated retention of a modified Medicare Cost Report to provide accurate data with which to assess the effects of the system on various hospitals. It also considered the report from an AAMC committee on paying for physician services in a teaching setting. Other topics highlighted at the COTH Board meetings were preparation for leadership in the teaching hospital/academic medical center and the role of the AAMC in assuring that such leadership training existed; the regulation on "Nondiscrimination on the Basis of Handicap," which dealt with instances in which severely handicapped infants were not treated; and the role of the AAMC in providing services to its member institutions. The COTH Board also reviewed and considered items on the Executive Council agenda which were of interest to the membership of the AAMC as a whole.

ORGANIZATION OF STUDENT REPRESENTATIVES

During this year 123 medical schools designated a student representative to the Association of American Medical Colleges, an increase of five from the previous year and the highest number in the Organization's history. Students from 106 schools attended the 1982 Organization of Student Representatives annual meeting. The first evening's program on "Nuclear Weapons, Denial Psychology, and Physicians' Responsibilities" drew a diverse audience and was offered by H. Jack Geiger, professor of community medicine, City College of New York; Tony Robbins, professional staff member, Committee on Energy and Commerce of the United States House of Representatives; and Bruce Dan, formerly with the Centers for Disease Control. On the next day, attendees heard presentations by Lawrence Weed, professor of medicine at the University of Vermont College of Medicine, on "New Premises and New Tools in Medical Education" and by John-Henry Pfifferling, director, Center for the Well-Being of Health Professionals on "Recreating the Joy of Medicine." Discussions stimulated by these sessions resulted in the formulation and approval of action plans on medical use of information systems, social responsibilities of physicians, housestaff concerns, financing medical education, programs for fostering personal growth and development, and improvement of teaching and evaluation techniques. Additional programs were given by Robert Lang and Alan Kliger, both associate professors of medicine from Yale University School of Medicine, on "Retaining Your Humanism in the Face of Technologic Explosion," and by Leah Dickstein, associate dean for student affairs, and Joel Elkes, professor of psychiatry and behavioral sciences, both from the University of Louisville School of Medicine, on "Creating Self-Help Programs".

The Board met prior to each Executive Council meeting to coordinate OSR activities, to consider Executive Council agenda items, and to share information on regional projects, including the OSR spring meetings. Administrative Board members prepared stimulus materials to encourage student participation in institutional activities related to the AAMC's General Professional Education of the Physician project. At its April meeting, the Board approved a proposal recommending that the Association explore mechanisms to achieve additional input from residents. The OSR chairperson presented this proposal to the Council of Deans Administrative Board at its June meeting. A new area discussed by the Board was the use of animals in biomedical research; it agreed that many medical students could benefit from reading a pamphlet on this subject produced by the Association of Professors of Medicine and copies were sent to OSR members. As in previous years, the Board nominated medical students for the position of student participant on the Liaison Committee on Medical Education and made appropriate information available to OSR members at schools with upcoming LCME site visits.

One issue of *OSR Report* was prepared by individual members of the Board and distributed to all medical students. It included essays on the National Boards, the need to develop teaching skills, loan repayment, career decisions, and creativity. Another publication provided to OSR members and to student affairs deans was a compendium of programs currently being offered at medical schools designed to assist students in choosing a specialty.

National Policy

The congressional override of President Reagan's veto of its 1982 supplemental appropriations bill was a harbinger of change in the climate for development of national policy. Besides representing the first Reagan loss on a major economic issue, the override displayed that Congress was capable of exacting compromise from the executive branch. This override carried by the slimmest possible margin in the the Republican Senate, with 30 Senators voting to uphold the veto and 60 voting for the bill. Many of the Republicans who objected to the President's veto did so on the grounds that the supplemental bill stayed within the spending boundaries of the FY 1982 budget resolution endorsed by the President, and that in opposing the bill he was flouting the spirit of executive-legislative compromise.

The AAMC was encouraged by the NIH research funding level of $4.004 billion included in the final continuing resolution for FY 1983, a welcome, if slight, increase above the amount requested by AAMC in testimony earlier in the 97th Congress. The funding level was insufficient to reverse the trend of a declining percentage of approved research projects receiving awards. The continuing resolution did not bring NIH funding, measured in constant dollars, up to its high-level mark in 1979.

Despite signs of an economic recovery, fiscal issues retained a paramount position in the political debate; legislators struggled to find a policy mix that would both boost the economy and remain politically palatable. President Reagan's FY 1984 budget reaffirmed his commitment to defense increases, cuts in social programs (characterized as a "freeze"), and only limited measures to raise revenues to reduce the deficit. These policies have particular implications for the Medicare program, which was a major target in the FY 1984 budget resolution reconciliation instructions.

The crunch on resources fragmented and paralyzed both the 97th and the 98th Congresses. For example, the Departments of Labor, Health and Human Services, and Education were funded by a continuing resolution rather that a normal appropriation act for the fourth consecutive year. In March, when the Democratic House passed its FY 1984 budget resolution, the bill was immediately branded as too costly, given the prevailing political environment of retrenchment. Then the Senate took three months to produce its FY 1984 budget resolution. The Senate Budget Committee's original bill and two alternatives were rejected on the Senate floor, and the Committee was instructed to redraft its resolution with no clear indication of what changes would muster a majority. The resolution that finally passed anticipated a $200 million increase in biomedical research, while calling for much larger tax increases and only half the increase in defense spending that President Reagan requested. The non-defense portion of the budget generally received small increases.

The House-Senate budget conference reached agreement after prolonged negotiations. That measure provided room for NIH funding to increase in FY 1984 by a substantial extent. This year's budget cycle was noteworthy for the marginal role that the White House played in forging a compromise and for Congress's two-month postponement of its July 22 reconciliation deadline. The Congress weathered an internal tempest in passing its budget resolution, which sets broad spending guidelines, but must exact a further set of compromises, this time from President Reagan, as it works on individual appropriations bills for FY 1984.

On the bright side, congressional support for research has been reinvigorated by a renewed belief that research expenditures have stimulating effects on the economy as a whole and that the government's commitment to research must be maintained, especially in the domain of sophisticated technology.

The Association was heartened by the renewed political popularity of research. However, it remains opposed to the ubiquitous calls for targeted research with related reorganizational and funding demands. These forces have left graphic imprints on NIH reauthorization bills in the House. In the 97th Congress, the Health Research Extension Act of 1982 would have mandated research centers, demonstration projects and other statutorily unnecessary activities that would bind the hands of the Appropriations Committees; limited the NIH Director's latitude to provide funding for research proposals showing the greatest scientific promise; and mandated numerous administrative changes in the NIH.

Conceivably even more disturbing than the recodification of administrative provisions and the statutorily imposed structural uniformity within NIH was language in the report accompanying H.R. 6457 that asserted that all necessary NIH au-

thority was included in Title IV of the PHS Act; this came dangerously close to eliminating access to the open-ended statutory authority of Section 301 of the Public Health Service Act. This authority is the bedrock upon which NIH has grown, and the severe limitation of this authority would mark a truly dramatic change in the operational framework of NIH. H.R. 6457 passed the House by a large margin, following heated debate about the most propitious relationship between the NIH and the Congress, but was never enacted, as the Senate version of the NIH reauthorization bill never came to a vote. An emergency, bare-bones compromise to reauthorize the NIH was unsuccessful, hence the National Cancer Institute and the National Heart, Lung and Blood Institute currently operate only because of the existence of the Section 301 authority and the fact that NIH is operating under a continuing appropriations resolution. This situation is a telling example of the utility of Section 301 authority.

The NIH authorization bill which Rep. Waxman introduced in the House early in the 98th Congress was almost identical to the one from the previous session, but it subsequently picked up a large number of additional undesirable and/or unnecessary provisions. AAMC presented testimony on this proposal, stressing that scientific opportunity is inherently unpredictable and requires organizational, operationl and funding flexibility so that the most promising research leads can be pursued. AAMC reiterated its concern over the additional administrative structures that the bill would impose upon the already adequate mechanisms within the NIH. Waxman's bill is opposed by the DHHS; there also is a group of Representatives who, impressed by the progress NIH has made in its current configuration and management structure, are determined to forestall further congressional encroachment. Highly charged floor debate has begun on H.R. 2350, with its opponents set to offer an AAMC-supported substitute reauthorization that is striking in its simplicity. The Senate is also about to consider its NIH reauthorization bill. The latter has fewer new provisions than the House companion, particularly in regard to NIH reorganization, but it is still too prescriptive in its contents to elicit AAMC endorsement.

The newly created Public Health Emergency Fund underscores the susceptibility of legislators to well-organized publicity campaigns. Once the Secretary certifies that a public health emergency exists, this $30 million fund authorizes expedited peer and advisory council review of relevant research grant applications. This legislation grew directly out of the concern engendered by the AIDS epidemic and the Tylenol package tampering tragedy. The bill's proponents have erroneously assumed that since the public perceives an emergency, unlimited research opportunities must also exist. The bill does not recognize that existing NIH procedures already permit a rapid commitment of research funds to meet unusual opportunities.

The funding picture for NIH remains precarious although there is some ground for optimism. The Administration's FY 1984 budget request for NIH of $4.077 billion, an increase over FY 1983 funding of 1.8 percent, was repudiated in the congressional budget process. The AAMC, through the Coalition for Health Funding, is working vigorously in the 98th Congress to increase government support for health research. The Association advocates a position taken by 133 other organizations to add a minimum of $487 million to the 1983 appropriations level for NIH funding. This figure would permit 35 percent of all competing projects to be funded; provide for 10,000 research trainees, about the average of the past 5 years; restore direct and indirect cost reductions proposed by the Administration; and support modest growth in all programs. The AAMC testified on behalf of this recommendation in late April before the Senate Subcommittee on Labor/HHS/Education Appropriations, chaired by Senator Lowell Weicker, as well as before Congressman William Natcher's House Appropriations Subcommittee. Another continuing resolution for Labor/HHS/Ed is highly probable, as only a few working days remain before the end of the current fiscal year.

The Alcohol, Drug Abuse and Mental Health Administration was a major beneficiary of the FY 1983 supplemental veto override. That appropriation provided an additional $10 million for research funding. The Secretary was also given discretionary authority to allot the research funds to areas of greatest need; most went to approved but unfunded investigator-initiated research grants.

The 98th Congress, extending the approach taken by 97th, swiftly authorized ADAMHA programs with especially generous authorization ceilings for the alcoholism and drug abuse research programs. The ADAMHA reauthorization bill mirrors trends in congressional initiatives concerning NIH. Thus the bill creates an associate administrator for prevention, establishes procedures for responding to fraud and abuse, and places new provisions on peer review of contracts and intramural research.

Medicare's projected trust fund insolvency looms ominously on the horizon. The trust fund had a balance of $18.7 billion just two years ago, but under current law it is expected to be in arrears by at least $200 billion by 1995. That figure represents approximately 23 percent of the entire federal budget for 1984. Medicare's fiscal problems stem from a projected 13.2 percent annual increase in Medicare costs, of which only 2.2 percent is at-

tributable to demographic changes. Most of the other increases are due to general inflation in the cost of capital and labor, as well as to the use of new and costlier technology.

The Medicare reimbursement system has only begun to implement drastic statutory changes enacted during the past year—TEFRA limits on hospital reimbursement and prospective reimbursement rates based on diagnostic related groups. However, there are already proposals circulating to respond to Medicare's financial difficulties. Many of these are primarily concerned with cost reduction, with assurance of adequate health care a distinctly secondary issue.

The growing constituency advocating more severe restrictions on the use of animals in research has monopolized a good deal of the AAMC's legislative energies. Animal welfare groups are gaining steadily in political sophistication, solvency, and emotional clout. In the 97th Congress Doug Walgren introduced H.R. 6928, "Humane Care of Animals Used in Scientific Research, Expermimentation and Testing," which would have created a number of onerous and costly provisions for those using animals to further their research. The bill would have required all laboratories using animals to receive AAALAC accreditation within ten years, at an estimated cost of $500 million. Further, the bill would have required institutional animal care committees responsible for determining if an acceptable substitute for research designs employing animals could be developed. The fact that NIH grant and contract approval procedures require explicit justification for the use of animals was apparently disregarded. H.R. 6928 also would have created an HHS grant program to develop alternatives to the use of animals in research. The AAMC's initial response to Walgren's proposal asserted that research on methodological issues alone placed a poor second to experimental design advances made in the course of directed research; there are powerful economic and experimental incentives built into animal research which encourage scientists to use animals sparingly and to keep them as healthy as possible; AAALAC's requirements exceed what is necessary to ensure the humane care and treatment of laboratory animals; and that the peer review system, not animals committees, can make the best determination of the appropriate use of animals in research. Walgren's bill passed through the Science and Technology Committee, but died in the Energy and Commerce Committee. Walgren continued his efforts in the 98th Congress and some animal care provisions were included in H.R. 2350, the NIH reauthorization bill. Through the efforts of the AAMC and other groups, these provisions are less burdensome than the ones originally proposed. They include the requirement to establish institutional animal care committees with responsibilities to visit laboratories using animals twice yearly and report to NIH; statutorily imposed guidelines for NIH funded research using animals; alternative methods research; and a study by the National Academy of Sciences on the use of animals in research.

In the 97th Congress Senator Robert Dole also entered the animals in research fray. His bill would have made standards in the Animal Welfare Act similar to those in the "NIH Guide for Care and Use of Laboratory Animals," on which AAALAC accreditation is based. Dole's bill would also have required research facilities to establish animal studies committees, which would meet regularly and make semi-annual inspections of research facilities. Senator Dole's bill did not emerge on the floor of the 97th Congress, but was reintroduced in 1983 and hearings were held in late July. The AAMC testimony objected to its particularly intrusive provisions, including the requirement that the Secretary of Agriculture promulgate standards for methodological procedures in research using animals. AAMC also expressed serious doubt about the capacity of the Animal and Plant Health Inspection Service to verify compliance with those standards and the wisdom of authorizing the animal studies committees to make judgments on the appropriate care, treatment and methodology of animals used in research, judgments properly within the province of national peer review committees. AAMC did endorse a NAS study on the issue of animals in research. This study is now included in both the House and Senate versions of the NIH renewal authority.

A potentially dangerous crosscurrent was added to the animal welfare debate when the Administration's FY 1984 budget request again proposed elimination of APHIS funding, eliminating support for federal oversight of the treatment of animals. The Administration proposed in its budget statement that the APHIS activity be turned over to "states, industry, humane societies, and individuals." AAMC testified on behalf of seven other societies and professional organizations for the retention of APHIS funding. Concerns expressed included the handling of violations while the new oversight system was being implemented, the imposition of different state regulations on institutions operating in several states, and regulation of interstate carriers. The Administration's proposal was rejected in an appropriations bill awaiting the President's signature.

This year, the Reagan Administration continued to reduce federal financial assistance for medical education. This occurs at a time of growing anxiety in the medical community about its ability to draw from the widest possible array of qualified students, given spiraling tuition charges and reports

of diminishing opportunities for newly trained physicians. Further concern stems from the continued inability of medical schools to increase enrollment of underrepresented minority students. The federal government remains the primary patron of medical educational opportunity, supplying over 80 percent of all student assistance. The Association has assigned a high priority to obtaining an adequate level of financial support to meet medical students' needs.

Of all the aid programs, the Health Professions Student Loan program endured the most uncertainty and controversy, beginning with much-publicized hearings chaired by Senator Charles Percy about the default rates for the program. In late August 1982 HHS issued proposed loan collection regulations so demanding that at least two-thirds of the schools in the program would have been rendered ineligible for further participation. AAMC expressed its objections to HHS, met with Senator Percy's staff in an attempt to soften the regulations, and, along with other health professions groups, retained counsel to work for modification of the regulations. The AAMC effort was modestly successful in helping to persuade HHS to adopt HPSL regulations that will tightly constrain medical schools in their administration of the program but will not, as feared, foreclose their ability to utilize it. Many schools have already stepped up their loan collection efforts, and by year's end Senator Percy was lauding them for lowered HPSL default rates. The HPSL program was further endangered by the low $1.0 million capital contribution included in the FY 1983 Continuing Resolution, and by an Administration FY 1984 budget request that provided no further capital contribution.

This year, the president once again attempted to restrict access to the Guaranteed Student Loan program. If adopted, Reagan's FY 1984 budget proposal would impose a needs test on all students, regardless of their income, and raise the loan origination fee to 10 percent of the amount being loaned, twice the current charge. The Guaranteed Student Loan program provides almost one-half of the financial aid utilized by medical students. The Administration's FY 1984 proposal for GSL was only slightly less odious than the one advanced the previous year, which would have eliminated graduate medical student involvement in the program altogether. That proposal alarmed the higher education community and was the target of an energetic, successful lobbying effort. This year's proposal was also rejected in all quarters. The program remains in place but needs to be reauthorized by 1985.

The HEAL Program was also the target of Reagan retrenchment but it ultimately received an FY 1983 credit allocation of $225 million, a more adequate level than the $80 million limit recommended in the first budget resolution. The AAMC successfully mobilized student support for this program when the unrealistically low credit ceiling was imposed. This limitation would have restrained access to the program at a point when its usage has increased substantially. The Administration's $175 million FY 1984 budget request for this program recognizes its current importance, but that credit ceiling is still too low to give all health students the loan funds they need. The nonbinding credit accounts in the FY 1984 congressional budget resolution will permit students to borrow to meet their full educational cost.

The programs administered by the Veterans Administration stood immune to the fiscal uncertainty which plagued the funding process in so many areas of AAMC interest. For both FY 1983 and FY 1984, HUD/Independent Agencies appropriation bills, under which the VA is funded, were passed by Congress and signed by President Reagan. The FY 1983 bill provided a welcome $12 million increase in medical and prosthetic research, activities that were increased in the 1984 bill by another $6 million. In its testimony before the relevant House and Senate Appropriations Subcommittees the AAMC stressed the need for research opportunities in veterans' hospitals so that able staff physicians and residents can be recruited and retained. Emphasis was also placed upon the need for higher operating budgets within VA hospitals to ameliorate the unsuitably low staffing ratios. The Association continued to oppose VA reimbursement for chiropractic service to veterans. In testimony before the House Veterans' Affairs Subcommittee on Hospitals and Health Care, the AAMC claimed that services of unproved medical value do not merit funding in a time of budgetary stress. A letter of similar thrust was delivered to the Senate Veterans' Affairs Committee; however, the Senate approved a measure which would authorize VA payments to chiropractors.

The National Research Service Award tax issue was finally resolved when the IRS reversed itself and ruled that the awards are to be treated as scholarships under the tax code. The newly declared tax-exempt status of the awards means that the entire amount of the awards for pre-doctorals is excludable from income tax, and that $300 a month is excludable in the case of post-doctorals. Legislation temporarily making the awards tax-exempt had passed the Congress a number of times and a bill to permanently define the tax status of the awards was pending as the IRS, responding to the urgings of the NIH as well as to congressional pressure, rendered the legislation superfluous.

Working with Other Organizations

The Council for Medical Affairs—composed of the top elected officials and chief executive officers of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Council of Medical Specialty Societies, and the AAMC—continues to act as a forum for the exchange of ideas among these similar but diverse organizations. Among the topics considered during the past year were the transitional year in graduate medical education, hospital staff organization, prospective payment, and concerns about the selection process for the second year of post-graduate training.

Since 1942 the Liaison Committee on Medical Education has served as the national accrediting agency for all programs leading to the M.D. degree in the United States and Canada. The LCME is jointly sponsored by the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges. Prior to 1942, and beginning in the late nineteenth century, medical schools were reviewed and approved separately by the AAMC and the AMA. The LCME is recognized by the physician licensure boards of the 50 states and U.S. territories, the Canadian provinces, the Council on Postsecondary Accreditation and the U.S. Department of Education.

The accrediting process assists schools of medicine to attain prevailing standards of education and provides assurance to society and the medical profession that graduates of accredited schools meet reasonable and appropriate national standards; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated. Survey teams provide a periodic external review, identifying areas requiring increased attention, and indicate areas of strength as well as weakness. During the past year, the LCME has begun the process of revising its accreditation standards for the evaluation of M.D. degree programs with the objective of providing an updated policy statement for subsequent consideration by the academic and practicing communities.

Through the efforts of its professional staff members, the LCME provides factual information, advice, and both formal and informal consultation visits to newly developing schools at all stages from initial planning to actual operation. Since 1960 forty-one new medical schools in the United States and four in Canada have been accredited by the LCME.

In 1983 there are 127 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences. Two have not yet graduated their first classes and consequently are provisionally accredited; the 125 schools that have graduated students are fully accredited. Additional medical schools are in various stages of planning and organization. The list of accredited schools is found in the *AAMC Directory of American Medical Education.*

A number of new medical schools have been established, or proposed for development, in Mexico and various countries in the Caribbean area. These entrepreneurial schools seem to share a common purpose, namely to recruit U.S. citizens. There is grave concern that these schools offer educational programs of questionable quality based on quite sparse resources. The ability of these foreign medical students to return to the United States for the practice of medicine will depend on their personal qualifications and backgrounds. However, it is anticipated that within the next five years the number of residency appointments available in the United States will closely match the number of students graduating from U.S. medical schools. Thus, M.D. degree graduates from foreign schools of unknown quality will have increasing difficulty in securing the residency training required by many states for medical licensure.

The Accreditation Council for Graduate Medical Education continued to improve the accreditation system for graduate medical education programs under the new General Requirements that became effective in July 1982. Residency Review Committees, whose special requirements no longer are subject to veto by their sponsors, were active in strengthening and clarifying their criteria for accreditation. Seven RRCs submitted changes in their special requirements for ACGME approval. In addition, the ACGME approved special requirements for four pediatric subspecialties (hema-

tology/oncology, nephrology, neonatal/perinatal medicine, and endocrinology). Plans for accrediting these and internal medicine subspecialties are being implemented.

The requirement that graduates of medical schools not accredited by LCME pass an examination equivalent to Parts I and II of the National Board of Medical Examiners examination before entry into graduate medical education programs was extended to include graduates who have taken a year of clinical clerkships sponsored by an accredited medical school. This brings the requirements for "fifth pathway" candidates into line with other foreign medical graduates. An ad hoc committee was established to explore the feasibility of evaluating the clinical skills of graduates of schools not accredited by the LCME by direct observation. The committee report will be considered by the ACGME during the next year.

Thirteen of 24 residency review committees have been granted independent authority to accredit programs without prior review by the ACGME. The actions of these RRCs are periodically surveyed by a monitoring committee to ensure that the RRCs comply with ACGME procedures and policies. An ad hoc committee to appraise the effectiveness of the accrediting process will report to the ACGME in fall 1983.

The Accreditation Council for Continuing Medical Education has gained approval of its new Essentials by all member organizations. This permits the Council to apply the principles and standards of the Essentials to the national accreditation of sponsors of continuing medical education including medical schools, national professional and specialty organizations, and other institutions.

The ACCME still must complete the development of its relationship to the state medical societies as accreditors of intrastate continuing medical education. The Council is seeking national recognition of such organizations through approval of procedures which assure adherence to national standards of accreditation while acknowledging the privilege of state societies to accredit local sponsors of continuing medical education. The acceptance and application of national standards for the accreditation of continuing medical education is considered an important step towards assuring the public and the profession of quality continuing education for physicians.

In response to widespread demands, the Educational Commission for Foreign Medical Graduates, in collaboration with the National Board of Medical Examiners, began to develop an extended certification examination equivalent to Parts I and II of the examination offered by the NBME. This new examination, the Foreign Medical Graduate Examination in the Medical Sciences, will replace both the original ECFMG examination and the Visa Qualifying Examination. The Secretary of Health and Human Services has declared this new examination equivalent to Parts I and II of the NBME examination for physicians seeking visas. The ACGME has given it provisional approval as the test required for graduates of non-LCME accredited medical schools to enter approved residency programs. FMGEMS will be offered for the first time in July 1984 and biennially thereafter. The ECFMG Board of Trustees also approved recognition of passing scores on all three parts of the FLEX examination for partial fulfillment of the requirements for obtaining the ECFMG certificate. Under this new policy, the requirements for entry into U.S. graduate medical education programs will be the same for all graduates of foreign medical schools. This accomplishes a long-standing goal of the Association.

The Coalition for Health Funding, which the Association joined with others in establishing 13 years ago, has expanded its activities and influence by monitoring and commenting on the development of the congressional budget resolutions in addition to its ongoing efforts on the appropriations process. The unpredictabilities in the evolution of the congressional reconciliation process presented new challenges to the Coalition and emphasized the importance of cooperation among organizations with similar interests. Widespread acknowledgement of the usefulness of the Coalition's annual position on appropriations for the discretionary health programs offers significant evidence of the respect with which it is held.

The diversity of the Association's interests and the nature of its constituency offers an unusual opportunity for liaison with numerous other organizations representing health care providers, higher education, and those interested in biomedical and behavioral research. The Association is regularly represented in the deliberations of the Joint Health Policy Committee of the Association of American Universities/American Council on Education/National Association of State Universities and Land-Grant Colleges, the Washington Higher Education Secretariat, and in the Intersociety Council for Biology and Medicine. These liaison activities provide forums in which information on matters of national interest can be shared, varying points of view reconciled, and collective actions undertaken in the area of federal legislation and regulation.

The Association's Executive Committee meets periodically with its counterpart in the Association of Academic Health Centers. This past year the organizations co-sponsored a conference on the implementation of the Medicare prospective payment system for academic medical centers.

Education

During the past year, the membership of the AAMC has expanded and extended its efforts to improve the education of the physician, particularly during the period preceding the M.D. degree. These activities have sought to identify problems in the existing system, to anticipate changes required to meet the future demands of the profession, and to study the options suggested by most recent advances in educational theory and practice. Such critical retrospection and self-evaluation involves risks, not the least of which is the acknowledgement that the current system contains deficiencies and can be improved. Despite an opportunity to adopt a defensive attitude, the medical schools have engaged in these programs enthusiastically and energetically.

The most conspicuous of these activities is the General Professional Education of the Physician and College Preparation for Medicine project. The GPEP project achieved considerable momentum during the year with active involvement of over 95 AAMC medical schools, four-year colleges from which medical students are drawn, and organizations and individuals engaged in medical education. The project is in the second year of a three-year effort supported by the Henry J. Kaiser Family Foundation.

The GPEP project has been successful in stimulating broad discussions among the medical school and college faculties about their philosophies and approaches to medical education and college preparation for medicine. The widespread interest in this project was evident when 98 different faculty and student groups appeared before the panel at regional hearings hosted by the University of California, San Francisco, School of Medicine, the University of Texas Medical School, Northwestern University Medical School, and the New York Academy of Medicine. Many others submitted written statements and reports.

To gain the particular perspective of college and medical school students, two special surveys were commissioned by the AAMC. Louis Harris and Associates, Inc. interviewed premedical students to obtain their perceptions of how the medical school admissions process had shaped their college education. The Center for Educational Development sampled second and third year medical students on their views on a variety of topics ranging from the efficacy of their scientific education to their personal relationships.

In July the panel under the chairmanship of Steven Muller, president of The Johns Hopkins University, met to review the working group reports, the testimony presented at regional hearings, the two special surveys, and the institutional and organizational reports. The major issues that have emerged in the course of the project will be debated at a special general session at the 1983 annual meeting. The final report will be presented to the Executive Council and published as a supplement to the *Journal of Medical Education* in late 1984.

The AAMC Group on Medical Education has been enthusiastic about the increased interest in medical education provided by the GPEP program. The project became an important focus for the GME and served as a basis for organizing discussions at regional and national levels. The GME is currently identifying research and development activities emerging from the GPEP-related discussions.

A joint 1983 plenary session with the Group on Student Affairs considered educational reform in the context of future societal change. In that session the impact of social, economic, political, and technological change on the profession and health care system was assessed and the implications for changes in educational practice weighed. The small group discussion sessions, educational exhibits, workshops, and special panels on continuing and minority education were also strongly influenced by the spirit of self-appraisal that has been increasingly evident with the advent of GPEP.

The Research in Medical Education Conference has also shown growing concern for broad educational issues. The RIME Committee established an Annual Invited Review of Medical Education Research for publication in the conference *Proceedings* and for presentation at the annual meeting. The first review, entitled "Measuring the Contribution of Medical Education to Patient Care," was prepared by Joseph S. Gonnella of Jefferson Medical College.

The RIME planning committee also recognized that better information about research and evaluation projects would encourage more attention to trends and general policy, so the *Proceedings* have been expanded to include the precis of all conference submissions.

The AAMC Clinical Evaluation Project has approached the improvement of the educational process by concentrating on evaluation during the clinical experience. The completion of the data-gathering phase was marked by the dissemination of 7,000 copies of *The Evaluation of Clerks: Perceptions of Clinical Faculty* and an accompanying editorial "Clinical Judgment of Faculties in the Evaluation of Clerks" from the March 1983 *Journal of Medical Education.*

The goals of the implementation phase are to develop self-assessment materials applicable at the institutional, departmental, and training site levels for identifying strengths and weaknesses of existing evaluation systems, and to offer specially selected evaluation options for addressing problems emerging from the self-assessment exercise. Activities include determining the ways in which medical schools will participate in the second phase, developing and testing of self-assessment materials, and defining and selecting the evaluation options.

The Clinical Evaluation Project encompasses the clinical continuum from the introduction of clinical medicine components in the pre-clinical years through the third year of graduate medical education. Although the main focus has been on the evaluation of medical students, activities covering all clinical education are planned. A consultant group will assist in addressing this challenge.

The need for more systematic information about experiments in curriculum and evaluation has prompted plans for a network for the exchange of such information.

In a more specific but highly critical area of the future education of the physician, the AAMC concluded its Regional Institutes on Geriatrics and Medical Education project. The Association published and distributed more than 4,000 copies of the proceedings from the four regional conferences and the Steering Committee's final report on "Undergraduate Medical Education Preparation for Improved Geriatric Care." During 1983, the Association, through the support of the Pew Memorial Trust, sponsored 50 visiting lectureships in geriatrics and gerontology for medical schools, teaching hospitals, and academic societies.

In addition to maintaining its efforts in the U.S. District Court in New York to protect the Medical College Admission Test in the face of that state's test disclosure law, the AAMC found it necessary to enter the federal court system in Philadelphia because of copyright violations involving MCAT test materials. Routine activities monitoring the security of MCAT test materials uncovered that the commercial test preparation operation, Multiprep, Inc., was in violation of AAMC copyright, for reproducing actual MCAT questions illegally removed from an MCAT test center. The AAMC immediately filed suit seeking to injoin Multiprep, Inc. from further use of the test materials and to recover damages. The AAMC also quickly identified and communicated with the examinees who had had access to the exposed materials and arranged to substitute valid scores for those that had been compromised by the practices of Multiprep. Approximately 250 examinees were given three separate opportunities to retake the MCAT at AAMC expense so their applications to medical school would not be delayed.

U.S. District Court Judge Raymond J. Broderick granted the AAMC's request for a preliminary injunction which prohibited Multiprep from using a number of specific practice test booklets, from advertising that Multiprep distributes and displays as "facsimile" or "replica" MCAT tests, or from infringing MCAT test forms and test questions. All information surrounding these events has been turned over to the Federal Bureau of Investigation and the U.S. Attorney's office in Philadelphia which are actively pursuing a criminal investigation of the individuals involved.

Work continued in the Continuing Education System Project conducted with the Office of Academic Affairs of the Veterans Administration, with the pilot testing of the concepts and products of the project. Within the Veterans Administration, the quality elements are being used for developing a self-assessment manual as a part of the quality assessment and assurance program for the Regional Medical Education Center. The manual provides a basis for organizational self-study and site visits. The manuscripts for a comprehensive book on continuing education and for learning packages on selected aspects of continuing education have also been completed.

All of these efforts did not preclude attention to the admissions process. Staff began investigating the feasibility of collecting a writing sample from all examinees during each MCAT administration. An experiment was approved that would provide time on the test day for examinees to prepare an essay on assigned topics. The writing sample is viewed as an opportunity to provide admission committees with a written composition, prepared by the candidate under conditions similar for all applicants. Copies of the essay would accompany each reported MCAT score.

Meanwhile, the AAMC continued to work with thirty medical schools participating in the MCAT

Interpretive Studies Program. A preliminary summary of the relationship between MCAT scores and performance in the first two years of medical school is in press. The report documents the predictive and incremental validity of MCAT scores. During the past year, the program entered its second phase, an examination of clinical science performance and its relationship to MCAT scores. Some studies suggesting significant correlations with fund of knowledge measures have appeared and staff has begun working with several schools to identify reliable and valid measures of performance in the clerkships as other criteria to explore.

Other studies were undertaken to determine how MCAT scores relate to categorical measures denoting academic problems such as withdrawals/dismissals for academic reasons and program deceleration.

Biomedical and Behavioral Research

Persisting concerns about the inadequacies of research funding for both the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration prompted a small number of organizations, including the Association, to develop a new strategy for approaching Congress about research appropriations. It was agreed that an effort should be made to secure agreement among a sizable number of organizations interested in those agencies on a single total figure for each. The funds would be allocated within those sums for individual institutes or activities in the subsequent appropriations process. The congressional response was highly favorable and played a role in obtaining substantial increases over the president's budget.

For the fourth consecutive year, the Congress did not pass a formal appropriations law for the Department of Health and Human Services. However, a final continuing resolution for FY 1983 provided a budget for the NIH of slightly more than $4 billion, compared to $3.6 billion in FY 1982. Although funding for clinical training was substantially reduced, the overall budget for ADAMHA was increased by $4 million to $272 million. Stimulated by that outcome, the Association and its initiating colleagues persuaded more than 130 organizations to join a similar effort on behalf of NIH for FY 1984. This was double the number of groups which had previously participated. Initial reactions from Capitol Hill have been most encouraging, despite the generalized concerns about mounting federal budget deficits.

It should be emphasized that this new approach embodies a strong commitment to all the programs of the NIH as well as the agency as a whole. In the past, the research community has strongly advocated sufficient funding to support a minimum of 5,000 new and competing renewal grants (RO1s) to stabilize the investigator-initiated project base. The highest priority continues to be placed on these awards, which hold the greatest promise for important discoveries. However, it has become apparent that in recent years, within the limits of a constrained NIH budget, the support of 5,000 RO1s has been accomplished only by partial funding and at the expense of other NIH programs. By way of illustration, the percentage of the NIH extramural budget devoted to RO1s grew from 44 percent in 1972 to 63 percent in 1982. Conversely, between 1972 and 1982, the percentage devoted to other research grants fell from 22 percent to 19 percent; for R&D contracts, from 18 percent to 12 percent; and for research training, from 12 percent to 5 percent. Despite the importance of assuring adequate support for these grants, this diversion of funds away from other important NIH activities greatly concerns the research community.

A related concern regarding the precise allocation of NIH funds has been the development of proposals designed to stretch federal research dollars. Proposed modifications include an arbitrary reduction of indirect costs to institutions, dollar limits on support to individual laboratories, an increase in the existing emphasis on RO1s as opposed to research centers and other grants, and the institution of a sliding scale for research grants to reduce the amounts of money awarded to applicants with higher priority scores and distribute the recovered funds to applicants with lower scores. The latter proposal has received considerable attention and is of particular concern given the fact that fiscal constraints have already prompted the NIH to fund new and competing grants an average 7 percent below study-section-recommended budgets. In addition, across-the-board reductions in non-competing renewal grants have been implemented in recent years. Following a thorough discussion of these issues at its January meeting, the AAMC Executive Council concluded that NIH-sponsored research would be poorly served by the implementation of any or all of the proposals to stretch research funds. Subsequently, the Association distributed a statement defending the present NIH grant system and actively endorsing the existing peer review process.

With regard to research sponsored by the Veterans Administration, the Congress passed a FY 1983 appropriations bill which increased funding for VA research programs to $154.8 million from $140.8 million the previous year. In mid-July, President Reagan signed a VA appropriations bill for FY 1984 which will provide $162.3 million for medical and prosthetic research, $6 million over the original budget request.

Faculty

The leadership of the Association has had a long interest in concerns of the faculties about scholarship, research, and research training. Research training for physician faculty, the apparent decline in the number of physicians entering research careers, and the difficulty of Ph.D. biomedical scientists in securing appropriate academic appointments are some of these concerns. To illuminate these concerns, the Association performs analyses and studies from time to time, based on ad hoc or regular surveys.

The Faculty Roster System, initiated in 1966, continues to be a valuable data base, containing information on current appointment, employment history, credentials and training, and demographic data for full-time salaried faculty at U.S. medical schools. In addition to supporting AAMC studies of faculty manpower, the system provides medical schools with faculty information for completing questionnaires for other organizations, for identifying alumni serving on faculties at other schools, and for producing special reports.

In spring 1983, the Association conducted a pilot study of research activity of faculty in departments of medicine, in cooperation with the Task Force on Manpower Needs of the Association of Professors of Medicine. The Faculty Roster provided basic demographic and appointment data for the medicine faculty, and, as a byproduct, the Faculty Roster itself was corrected and brought up-to-date for the schools participating in the pilot project. The results of the pilot study were encouraging, and the Association agreed to support a full survey of all faculty in departments of medicine, again in cooperation with APM. The study will determine the extent of faculty research activities, sources of funding for research, publication activity, and amount of assigned research space.

During 1984 the Faculty Roster data base will be matched to NIH records on research training and on research grant applications and awards, to analyze the relationship between training and academic careers, and the faculty's role in the conduct of biomedical research. These activities, as well as the maintenance of the Faculty Roster data base, receive support from the National Institutes of Health.

Based on the Faculty Roster, the Association maintains an index of women and minority faculty to assist medical schools and federal agencies in affirmative action recruiting efforts. Since 1980 approximately 700 recruitment requests from medical schools were answered by providing records of faculty members meeting the requirements set by search committees. Faculty records utilized in this service are those for individuals consenting to the release of information for this purpose.

To apprise medical school affirmative action offices of the existence of the index, descriptions of the index, as well as statistics developed from the roster to assist in affirmative action planning, have been forwarded to staff members at medical schools.

As of July 1983 the Faculty Roster contained information on 49,646 full-time salaried faculty and 2,562 part-time faculty. The system also contains 51,172 records for persons who previously held a faculty appointment.

The Association's 1982–83 *Report on Medical School Faculty Salaries* was released in January 1983, providing compensation data for 124 U.S. medical schools and 33,701 filled full-time faculty positions. The tables present compensation averages and percentile statistics by rank and by department for basic and clinical science departments. Many of the tables allow comparisons according to school ownership, degree held, and geographic region.

Students

As of September 2, 1983, 35,120 applicants had filed 317,833 applications for the entering class of 1983 in the 127 U.S. medical schools. These totals, although not final, represent a one percent decrease in the national applicant pool for the 1983 entering class over the previous year.

The total number of new entrants to the first year medical school class decreased from 16,644 in 1981–82 to 16,567 in 1982–83, while total medical school enrollment rose from 66,298 to 66,748. Although the actual number enrolled is the largest ever, the increase in total enrollment represents the smallest growth in the past ten years.

The number of women new entrants reached 5,210, a two percent increase since 1981; the total number of women enrolled was 19,597, a 5.6 percent increase. Women held 29.4 percent of the places in the nation's medical schools in 1982–83 compared to 24.3 percent five years earlier.

The number of underrepresented minority new entrants equaled 1,387 or 8.4 percent of the 1982–83 first-year new entrants, compared to 1,422 or 8.6 percent in 1981–82. The total number of underrepresented minorities enrolled was 5,544 or 8.3 percent of all medical students enrolled in 1982–83; compared to 5,503 (8.3 percent) in 1981–82.

The application process was facilitated by the Early Decision Program. For the 1983–84 first-year class, 883 applicants were accepted by 65 medical schools offering such an option. Since each of these applicants filed only one application rather than the average 9.1 applications, the processing of more than 7,000 additional applications and scores of joint acceptances was avoided. In addition, the program allowed successful early decision applicants to finish their baccalaureate programs free from concern about admission to medical school.

Ninety-eight medical schools participated in the American Medical College Application Service (AMCAS) to process first-year application materials for their 1983–84 entering classes. In addition to collecting and coordinating admission data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admission, matriculation, and enrollment.

The Advisor Information Service circulates rosters and summaries of applicant and acceptance data to subscribing health professions advisors at undergraduate colleges and universities. In 1982–83, 302 advisors subscribed to this program.

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

The total number of MCAT examinees tested for each of the past several years has remained relatively stable. With the exception of a seven percent decrease in examinations administered between 1978 and 1979, the change for any one year period has not exceeded three percent. The reduction of one percent in total examinee volume from 1981 to 1982 is attributable primarily to a decrease in repeating examinees, who accounted for 32.4 percent of all tests administered in 1982.

The Medical Sciences Knowledge Profile examination was administered for the fourth time in June 1983 to 2,080 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC to evaluate individuals seeking advanced placement. While 6.1 percent of those registering for the test had degrees in other health professions, 87.5 percent of all registrants were currently enrolled in a foreign medical school.

Monitoring the availability of financial assistance and working to insure adequate funding of the federal financial aid programs used by medical students are major activities of the AAMC. As indebtedness levels and medical school costs rise, concerns about both adequacy and availability of financial aid and increasing levels of student indebtedness continue to grow. These concerns motivated development of a plan for a study of medical student financing to be carried out in 1983–84 with the support of the Department of Health and Human Services. The Association also worked closely with the schools and HHS to monitor delinquency rates in the Health Professions Student Loan program, and to reduce those rates. Current authorization for all federal programs of student assistance in the Higher Education Act of 1965 and the Health Professions Education Assistance

Act of 1976 and subsequent amendments will be renewed in 1985. Because the aid programs are vital to medical students, the AAMC has made a great effort to obtain the necessary reauthorizations. The AAMC has also been involved in the development of a financial planning and management manual for medical and pre-medical students and their families.

The Association concluded a series of 17 student financial management strategy seminars funded by the Robert Wood Johnson Foundation. These programs spanned five years and reached over 2,000 financial aid officers, deans, student affairs deans, minority affairs officers, health professions advisors and students from schools of medicine, osteopathic medicine and dentistry.

The AAMC, through its Office of Minority Affairs, is administering several projects funded by the Division of Disadvantaged Assistance (formerly the Health Careers Opportunity Program) of the Department of Health and Human Services to enhance opportunities for minorities in medical education. One grant provides three types of workshops to reinforce and develop effective programs for the recruitment and retention of students underrepresented in medicine. The Simulated Minority Admissions Exercise Workshop provides opportunities for medical school personnel to improve their programs related to the admission and retention of minority students; the Retention and Learning Skills Workshop assists medical school personnel concerned with academic performance and retention of minority students; and the Minority Student Financial Assistance Workshop assists student financial aid program administrators, and premedical advisors to develop efficient and effective administration of financial aid programs for financially disadvantaged students.

A second grant, an evaluation of retention activities in medical schools, supplements existing efforts of retention programs by measuring the effect of these programs on attrition of minority medical students. In addition, the Robert Wood Johnson Foundation is supporting the development and distribution of an annual report on the status of minorities in medical education. Other work is also being carried out in conjunction with the Macy Foundation to determine the extent of minority medical student participation in special enrichment or preparatory programs.

A joint project involving AAMC, the UCLA Clinical Scholars Program, and the Rand Corporation to analyze the specialty choices and practice locations of minority and non-minority graduates of the medical school class of 1975 is nearing completion. Preliminary results indicate that the minority graduates are more involved in primary care and serve a higher proportion of minority and Medicaid patients than their non-minority peers. The project is supported by the Commonwealth Fund.

The Group on Student Affairs-Minority Affairs Section (GSA-MAS) held a Medical Career Awareness Workshop for minority students at the 1982 AAMC Annual Meeting. Two hundred high school and college students attended and fifty-four medical schools were represented. A similar workshop will take place at the 1983 annual meeting.

The annual medical student graduation questionnaire was administered to the class of 1983 in 123 of the 124 medical schools with seniors. A total of 10,481 students participated in the survey, a response rate of almost 66 percent. The majority of the 1983 respondents planned residency training after graduation. The most frequently selected areas of specialization were internal medicine and family practice. Twenty-five percent of 1983 graduates were considering a research-related career as compared to 22 percent in 1982. The average medical school debt of indebted respondents increased 12 percent to $22,694. Almost one quarter of the respondents had a total educational debt of $30,000 or more, compared to 18.4 percent in 1982. A summary report comparing national responses with individual institutional data was mailed to each school in September. Selected results appear in the 1983 Directory of the National Resident Matching Program.

The Graduate Medical Education Application for Residency, developed by the AAMC at the recommendation of its Task Force on Graduate Medical Education and distributed by the National Resident Matching Program, was utilized for the third consecutive year. Medical school student affairs offices distributed applications with the NRMP materials to students wishing to enter residency programs. The universal application form facilitates the process of applying for a residency position by providing a standard form for communication of basic information.

Work was completed on *Physicians in the Making: Personal, Academic, and Socioeconomic Characteristics of Medical Students From 1950 to 2000* as a part of the AAMC Series in Academic Medicine published by Jossey-Bass. The book contains information, predictions, and recommendations about aspiring applicants, enrolled students, and graduating seniors during the latter half of the century. A second related volume to be published by the Association, *U.S. Medical Students, 1950–2000: A Companion Factbook for Physicians in the Making,* provides more detailed statistical and bibliographic information. The Commonwealth Fund helped finance this project.

Institutional Development

After ten years of operation, the Association's program to strengthen the management capabilities of medical schools and academic medical centers received a comprehensive review by an ad hoc committee convened for that purpose. In recent years the program had emphasized its Executive Development Seminars, intensive week-long courses on management theory and technique for senior academic medical center officials. The review committee recommended that these seminars be continued but modified, and urged that the AAMC define a new mission of continuing management education for its members. The Executive Development Seminars would be provided biennially for new deans and periodically for department heads and hospital directors on a tuition-supported basis.

The committee's recommendations were adopted by the Executive Council in January. The first initiative under the new continuing management education mandate was the presentation of four seminars on "Medicare Prospective Payment System: Implications for Medical Schools and Faculties." Similar programs were conducted in Houston, Oakland, Chicago, and Philadelphia. These described the major features of the new prospective pricing system to be used to determine the Medicare payment for hospital care, identified the changed incentives and constraints facing teaching hospitals and their implications for medical schools and their faculties, and described internal management strategies needed to adapt to the new system. More than four hundred deans, hospital directors, department chairmen and other medical center officials attended the sessions and rated them very highly in terms of their interest and utility. Videotapes of some of the sessions were made available to member institutions for a nominal fee.

Planning was also undertaken to design short intensive workshops on financial management, information management, human resources management, and marketing. These workshops, scheduled to begin in spring 1984, will combine an emphasis on fundamental concepts with illustrations and exercises highlighting their applicability to current medical center issues and problems.

The Executive Development Seminar for new deans was conducted in August at Dedham, Massachusetts with 23 participating deans. Twenty hospital executives and 17 department chairmen participated in a September seminar in Florida. A similar but more compressed program was offered for Women in Academic Medicine during the summer. Forty-four women in key managerial positions brought the total number of Executive Development Seminar participants to 2,084 over the life of the program.

New projects under way include a more systematic effort to collect and make available information about members' use of consultants in dealing with management issues arising at academic medical centers. Also in process is a survey of faculty employment policies and procedures undertaken at the initiative of the Group on Business Affairs with the endorsement of the Council of Deans Administrative Board. Current plans are to develop a set of publications which will identify respondents to specific questions so that members can contact others with similar or contrasting approaches to particular issues, and which will also analyze selected trends in tenure related policies and practices.

Teaching Hospitals

The Association has focused attention on the Medicare Prospective Payment System adopted as part of the Social Security Reform Act of 1983 and on the regulations implementing the requirements of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). Additionally, the Association continued its major role in advancing support for health planning on both a state and local level. The Association opposed the modifications in the standards of the Joint Commission on Accreditation of Hospitals which would have opened the hospital medical staff organization to nonphysician practitioners; sought to temper the Department of Health and Human Services regulations on "Nondiscrimination on the Basis of Handicap," which would interject HHS into decisions on provision of care for severely handicapped infants; fought legislation that would have precluded hospitals and other not-for-profit organizations from obtaining tax-free bond financing for major capital projects; and drafted a report on "Payment for Physician Services in a Teaching Setting."

The regulations implementing the Tax Equity and Fiscal Responsibility Act set forth how physicians practicing in an institution would be paid for services, when assistants at surgery would be paid, and redesigned the Medicare limits on hospital payments. The regulation establishing the limits on payments for hospital-based physicians sought to distinguish clearly between services provided to the institution or to the patient population as a whole (Part A services) and services rendered to an individual patient (Part B services). Once separated, it was intended that Medicare would pay on a reasonable cost basis for services provided to the institution and on a reasonable charge basis for services provided to individual patients. Confusion over the original wording of this regulation led the Association to conclude that if a physician assigned fees to a medical school or practice plan and accepted a salary from that entity, then Medicare would restrict his fees to the amount of his salary. Through efforts of the Association, a memorandum from a high ranking HCFA official clarified that the rule was not intended to jeopardize faculty practice plans. The TEFRA regulation also specified changes in the way in which Medicare would pay for services of radiologists, anesthesiologists, and pathologists. In changing the radiologists' payments, HCFA sought to distinguish between physicians who must pay their own overhead and operating costs out of the fee charged and those for whom the hospital pays the overhead and staff salaries. Those services generally available in a physician's office will be subject to a limit of 40 percent of the prevailing fee for office-based services when provided by a hospital-based radiologist. For anesthesiologists, full payment of fees was limited to services during which they conducted no more than four concurrent procedures. Otherwise, anesthesiologists were considered to be acting as supervisors and subject to payment on a reasonable cost basis only. Lastly, the majority of clinical laboratory tests were defined as part A services payable on a reasonable cost basis rather than on a charge basis.

In an attempt to distinguish between physicians practicing in a hospital clinic where the hospital was paid on a cost basis for the overhead expenses and those running their own office-based practice, HHS published a regulation limiting physician charges for services furnished in hospital outpatient departments. Where a particular service is commonly provided by a physician in a private office setting, the fee of a physician performing that same service in a hospital-based clinic would be reduced to 60 percent of the Medicare prevailing fee for non-specialist physicians. Certain services were excluded from this reduction, including emergency, ambulatory surgery, and radiology services. The AAMC has strenuously objected to two aspects of this rule. First, it objected to the absolute nature of the regulation which disallowed fees if the hospital claimed reimbursement for any clinic overhead expenses. Since both the overhead allocation required on the Medicare cost form for hospital expenses and the additional functions of a teaching hospital such as the education of residents require more costs to be allocated to the clinic service than a physician practicing in a private office setting would incur, the Association argued the regulation was not equitable, and suggested that a more reasonable approach, would be to allow physicians to collect a full fee if the carrier

concluded the overhead costs paid to the hospital by the physician were equivalent to those in a private office setting. Secondly, the Association objected to the use of non-specialist fees as the base from which the determination would be made, since many of the physicians providing services in hospital clinics are specialists caring for patients referred to them by physicians in private office settings. As yet, no changes have been made to accommodate the Association's objections to this rule.

HCFA's new rules implementing TEFRA also preclude payment for an assistant at surgery when the hospital has residency programs in the specialty and residents were available to assist during the surgery. Through the efforts of the Association, this rule was clarified to allow a physician not participating in the educational program to have an assistant at surgery paid by Medicare. Also, the Association's efforts led to HCFA's acknowledging that residents have other duties besides performing direct patient care, and may be unavailable because of educational or research activities. In such circumstances, Medicare will pay fees for an assistant at surgery. Hospitals that participate in the approved programs of other hospitals are not affected by this policy.

In addition to the rules on physician payment, TEFRA and its implementing regulations established two limits on hospital payment. The first, called the target rate, used the hospital's own base year cost adjusted for inflation to constrain the increase in Medicare payments. The second limit was an expansion of the existing routine operating cost limit to include special care unit and ancillary service costs. The revision sets ceilings on hospital expenditures based on average costs per admission adjusted for case mix using the diagnosis related groups (DRGs). In this limit, HCFA compared costs across hospitals after adjusting for their case mix variation and differences as a result of the labor market area in which the hospital is located. Significantly, capital and direct medical education costs are excluded from the limit and a special adjustment, based on a hospital's resident-to-bed ratio, is provided for the so-called indirect medical education costs.

As mandated by TEFRA, HHS sent a Prospective System for Medicare to Congress. The proposal suggested establishing rates for each DRG. These same rates would have been paid to every hospital except children's and psychiatric hospitals; the only adjustment to the rates would have been to reflect the price of labor in the hospital's community.

The Association expressed five broad policy concerns with this proposal while testifying before the Senate Finance Committee's Subcommittee on Health and the House Ways and Means Subcommittee on Health. The AAMC noted that crucial details of the payment scheme were missing from the proposal, including the computation of the "pass through" of direct medical education and capital costs, the treatment of costs of atypical cases, and the procedure for determining indirect medical education costs. Additionally, the AAMC asserted that methodological refinements could not compensate for inadequate payment under the Medicare program and reminded Congress that the Medicare payment system is a normative statement of the government's values, not just a technical issue. The AAMC predicted that the burden of reduction in Medicare expenditures would be unevenly distributed among types of hospitals, disproportionately harming teaching institutions because allowances were not made for differences in hospital size and scope of service, disparities in severity of illness of patients within diagnostic groupings, inadequate information in the HHS data base with which to properly classify patients into DRGs, and methodological problems that overestimate the cost of routine care while underestimating the cost of tertiary care. A more evolutionary change in the payment mechanism was advocated so that the higher cost in teaching institutions could be properly evaluated and not assumed to represent inefficiency, waste, or poor management. Finally, the threat to hospital-physician relationships engendered by this proposal was raised.

The AAMC assertion that the administration's proposal would disproportionately harm some groups of hospitals was borne out in estimates from the Congressional Budget Office, presented at the Ways and Means Subcommittee hearing, showing that teaching hospitals and other large hospitals would suffer substantial losses under the proposed scheme while small and rural hospitals would gain sizable windfalls.

Congressional amendments to the administration's proposal resulted in the adoption of a prospective payment scheme that included a four-year phase-in of the DRG payments, the use of regional and national rates to ease the transition, an adjustment for teaching hospitals based on their resident-to-bed ratios, a requirement that unusual cases ("outliers") constitute between 5 and 6 percent of total per case payments, and a provision for special adjustments for national and regional referral centers. These amendments tempered CBO's estimates of the adverse effects of the new payment system for teaching hospitals, although the effect on individual hospitals is unclear. This was passed by Congress in late March and signed into law on April 3, 1983. Staff of the Association continue to work with the HHS as it develops regulations to implement this law. The staff has provided comments to HCFA on the method of calculating the base period cost, the appropriate mechanism for

assigning patients to DRGs, methods for calculating the adjustments for outliers and other patients requiring special care, and the appropriate method for computing the resident-to-bed ratio.

While Congress was considering the new payment system for hospital services, debate over the continuation of the health planning program resurfaced. The AAMC had endorsed a compromise health planning bill introduced in the fall of 1982 by Representatives Henry Waxman, Edward Madigan, Richard Shelby, John Dingell, and James Broyhill. This measure, adopted by the House of Representatives on September 24, made funds available for state and local planning activities.

The Senate had also proposed to continue planning in a bill sponsored by Senators Daniel Quayle, Orrin Hatch, Paula Hawkins, David Durenberger, and Daniel Inouye. The Senate bill was more restrictive of its allocation of funds and precluded states from regulating the planning, allocation, financing, or delivery of health care resources and services. A compromise resolution failed to come to a vote in the Senate before the end of the Congress and health planning survived only by a continuing resolution.

Health planning advocates in Congress resumed their efforts to obtain an authorization for a new health planning program in spring 1983. Representative Waxman's "Health Planning Amendments of 1983" emphasized the need for such legislation until capital costs are included in the DRG-based prospective payment system. A counter-proposal, by Representatives Madigan and Shelby was defeated in committee, but the staff of the Association and several other health organizations helped develop a health planning compromise proposal. It is felt that this bipartisan approach would have a greater chance of enactment in the Senate.

Of concern to the teaching hospitals, especially those caring for a substantial number of critically ill infants, were attempts to regulate the treatment decisions for handicapped infants. The first attempt, a regulation entitled "Nondiscrimination on the Basis of Handicap" was published March 7 and became effective March 22. It required hospitals to post notices stating the government's prohibition on withholding customary medical care or nutrition from an infant solely on the basis of its handicap, and it offered a toll free number for the anonymous reporting of suspected violations of this law to the office of civil rights.

The Association and other organizations, including the American Academy of Pediatrics and the National Association of Children's Hospitals and Related Institutions, protested that this rule interjected the HHS into the sensitive and highly emotional atmosphere in which parents, physicians, and other health care personnel make very difficult decisions about the care of an infant. On March 21 the AAMC wrote to Secretary Heckler urging a delay in the implementation of this rule to address the concerns of health care providers. The Association expressed concerns that the posted notices and the toll-free number would needlessly add to the stress of the parents and health care personnel.

The Association's request for delay and those of the other associations and organizations involved went unheeded; however, AAP, NACHRI, and Children's Hospital National Medical Center in Washington, D.C. were successful in a suit filed in the Federal District Court of the District of Columbia. The favorable ruling was based largely on procedural issues.

After deciding not to appeal to a higher court, HHS published revised regulations on July 6. While the substance of the Department's regulations had not changed significantly, the Department is taking all proper procedural steps in issuing this regulation and has attempted to address several of the judge's concerns in the preamble. The Department has also included state child protection agencies in the enforcement of this regulation.

This inclusion of the child protection agencies parallels a measure introduced by Representative John Erlenborn and Senator Jeremiah Denton. They proposed revising the Child Abuse Prevention and Treatment Act to require the posted notices and "hot line" approach. While expressing a continuing commitment to provide medically indicated treatment and nutrition to infants with life-threatening conditions, the AAMC wrote urging that this legislation be rejected. In particular, the AAMC objected to the coupling of the medical treatment decisions with child abuse legislation and the use of "hot lines" to monitor conformance. The Association expressed dissatisfaction with the assumption that child abuse protection agencies had the necessary training or staff to assess these cases and to supply technical assistance on the question of denial of appropriate care to severely impaired infants. Further, the AAMC criticized the diversion of scarce resources from the important task of investigating child abuse to the examination of complex and very difficult treatment decisions for impaired infants. The AAMC again objected to the unjustifiable increase in anxiety levels of families of critically ill infants. A more appropriate solution would be the one advocated by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in its report "Deciding to Forego Life Sustaining Treatment," which advocated that local review bodies establish policies and maintain standards for the care given in these cases. This piece of legislation has been substan-

tially modified to address some of the concerns about its provisions and is still pending before the House and Senate.

Again this year, the issue of tax-exempt bonds to finance major capital projects in hospital and educational institutions came to the forefront of the Association's agenda when some members of Congress sought to severely restrict the use of tax exempt bonds by non-profit organizations. The Association wrote to members of the Senate Finance and House Ways and Means Committees urging them to stand by the determinations made last year. The AAMC reminded them of the rationale for supporting this decision which included: tax-exempt revenue bonds support activities to provide a healthier and better educated public; the federal tax revenue lost as a result of the issuance of these bonds is minuscule and there is no evidence that nonprofit hospitals and educational institutions use tax-exempt financing inappropriately.

In another arena, the Joint Commission on Accreditation of Hospitals had proposed an amendment to its accreditation manual that would have changed "medical staff" to "organized staff" in defining the authority to admit and provide medical care to patients. Organized staff included licensed physicians and other individuals who qualify for clinical privileges and are licensed for independent provision of patient care services. At the January Administrative Board meeting of the Council of Teaching Hospitals, Dr. John Affeldt, JCAH president, told the board of JCAH's decision to make this change after having been advised by its attorneys that it was risking charges of restraint of trade. The AAMC criticized this change, stating it would alter the "long held concept that physicians have legitimate responsibility for ensuring that high quality medical care is provided in our nation's hospitals." The AAMC noted the difficulties in defining uniform eligibility criteria when professionals with a variety of licenses and degrees are allowed on the staff. The result would be a diminished ability to provide quality assurance for the care provided. The JCAH would simply be shifting the locus of the legal actions from itself to the hospitals.

The Association staff, under the guidance of a Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, published two technical reports early in 1983: *A Description of Teaching Hospitals' Characteristics* and *Selected Data on a Small Sample of Teaching Hospitals.* These books provide information on the services rendered in COTH member institutions as well as some of the characteristics of the patients admitted to these hospitals. Also published were annual surveys on housestaff stipends, funding, and benefits, chief executive officers' salaries, and university-owned teaching hospitals' financial and general operating data.

In conjunction with the Association of Academic Health Centers, the AAMC published a staff report which was the result of a conference on the implementation of the Medicare prospective payment system for academic medical centers. The Association also developed a report entitled, "Medicare Payment for Physician Professional Services in a Teaching Setting" under the guidance of the Committee for Payment for Physician Services in Teaching Hospitals.

Communications

Two studies and a round of legal actions generated much news media attention on the AAMC during the past year. News conferences in Washington, D.C. and New York City in October announced that the Association's General Professional Education of the Physician project was about to enter the second year of a three year effort supported by the Henry J. Kaiser Family Foundation. Additional news conferences were held in San Francisco and Houston as the panel began a series of four regional hearings where college faculty, medical school faculty, administrators and students were invited to discuss their views on medical education. These news briefings focused much national attention on the project. A final report will be issued in fall 1984.

A February news conference in Washington, D.C. reported the five recommendations of an AAMC study on improving the teaching of geriatrics to medical students. Joseph Johnson, chairman, Department of Medicine, Bowman Gray School of Medicine and chairman of an 11-member AAMC committee, and AAMC President John A. D. Cooper met the press. This news conference was the culmination of a year-long effort supported by the Pew Memorial Trust and the National Institute on Aging. The report received extensive nationwide coverage by newspapers, television and radio.

The third major event involving mass media coverage occurred in June when the Association discovered that Multiprep, Inc., an Ardmore, Pennsylvania testing preparation company, had secured copies of MCAT test forms and test questions and was illegally using them in its coaching courses. The AAMC's $1.5 million damage suit against Multiprep, Inc. and its owner and related legal actions have been actively followed by the news media.

In addition, the Association continues to interact with the national news media and responds to more than 25 media requests for interviews, information and policy positions each week.

The chief publication of the AAMC continues to be the *AAMC President's Weekly Activities Report*, published 43 times a year and circulated to more than 7,200 individuals. Each publication reports on AAMC activities and federal actions having a direct effect on medical education, biomedical research and health care.

The *Journal of Medical Education* published 999 pages of editorial material in the regular monthly issues, compared with 1,018 pages the previous year. The published material included 83 regular articles, 66 communications, and 11 briefs. The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine. The *Journal's* monthly circulation averaged 6,350.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1982–83 totaled 393, of which 137 were accepted for publication, 198 were rejected, 10 were withdrawn, and 48 were pending as the year ended. Two supplements carried as part of the regular issues were produced: "Preparation in Undergraduate Medical Education for Improved Geriatric Care," and "AAMC Annual Meeting and Annual Report, 1983."

About 24,000 copies of the annual *Medical School Admission Requirements*, 4,000 copies of the *AAMC Directory of American Medical Education*, and 7,000 copies of the *AAMC Curriculum Directory* were sold or distributed. Other publications, including directories, reports, papers, studies, and proceedings were also produced and distributed by the AAMC. Newsletters include the *COTH Report*, which has a monthly circulation of 2,650; the *OSR Report*, which is circulated twice a year to medical students; and *STAR* (Student Affairs Reporter), which is printed twice a year and has a circulation of 1,000.

The AAMC Series in Academic Medicine, published by Jossey-Bass, Inc., issued its third volume, *Physicians in the Making: Personal, Academic and Socioeconomic Characteristics of Medical Students from 1950 to 2000.* Three other manuscripts are in preparation.

Information Systems

The Association continues to upgrade its general purpose computer system to ensure that the information systems support will meet the ever-increasing needs of the Association membership and the staff. A Hewlett Packard 3000, Series 64 has replaced an aging Hewlett Packard 3000, Series III, and high density disk storage has been increased. Many of the high volume printing requirements are produced on a high speed laser printer, which currently produces an average of 2.7 million pages per month, largely related to the AMCAS program. With over 100 terminals accessing the Association files, there is a constant demand for more detailed information. Data bases continue to be developed to minimize data redundancy and to provide responsive, on-line retrieval of reliable information. By using expanded computer generated graphic art, it is now possible to provide illustrations in final publication form, thereby reducing camera art preparation and outside printing expenses.

While the cyclic processing of the individual students applications to medical schools continues to be a major information systems focus, the overall efficient data entry, verification and file building process remains the key to providing constituents with reliable information on students, faculty and institutions.

The American Medical College Application Service system is the core of the information on medical students. This centralized application service collects and processes biographic and academic data and links these data to MCAT scores for report generation and distribution to participating schools. This service also enables the individual schools to receive the most current update of a particular applicant's file. Roster, daily status reports, and summary statistics prepared on a national comparison basis are supported by an extensive and sophisticated software system and provide medical schools with timely and reliable information. Rapid on-line retrieval enables the Association to advise applicants of the daily status of their individual information. After data collection is complete, the system generates data files for schools, applicant pool analyses, and provides the basis for entering matriculants in the student records system.

AMCAS is supplemented by other systems, including the Medical College Admission Test reference system of MCAT score information, a college information system on U.S. and Canadian schools, and the Medical Science Knowledge Profile system on individuals taking the MSKP exam for advanced standing admission to U.S. medical schools.

A student record system maintained in cooperation with the medical schools contains enrollment information on individual students, and traces their progress from matriculation through graduation. Supplemental surveys such as the graduation questionnaire and the financial aid survey augment the student record system.

After the residency match in March of each year, the National Resident Matching Program conducts a follow-up study to obtain information on unmatched participants and eligible students who did not enroll. Beginning with the 1983 match, the Association, using an initial data file supplied by NRMP, produced match results listings for each medical school, updated the NRMP information using current student records system data and listings returned from the medical schools, prepared hospital assignment lists for each medical school, and generated a final data file for use in NRMP's tracking study.

The diverse information systems of the Association each serve a unique purpose. As special requests for information continue to increase, it has become necessary to consolidate these multiple systems into one Student and Applicant Information Management System. This new system, presently in the design stage, will produce a wide variety of reports describing students, applicants and graduates, answer special data requests for information from constituents, and provide data study files for additional statistical analysis.

Through the cooperation of the medical school staffs, Association personnel update the Faculty Roster System's information on the background, current academic appointment, employment

history, education and training of salaried faculty at U.S. medical schools. These data are periodically reported to the membership in summary format, enabling the schools to have an organized, systematic profile of their faculty. The Association conducts an annual survey of medical school faculty salaries. This Faculty Salary Survey System provides the annual report on medical school faculty salaries and is available on a confidential, aggregated basis in response to special queries.

The Association continues to maintain a repository of information on medical schools of which the Institutional Profile System is a major contributor since it contains data concerning medical schools from the 1960s to the present. It is constructed both from survey results sent directly from the medical schools and from other information systems. This system, containing over 20,000 items, is used for on-line retrievals and supports research projects.

The information reported on Part I of the Liaison Committee on Medical Education annual questionnaire complements the Institutional Profile System. Current year information is compared with data from the preceding four survey years and is used to produce the report of medical school finances published in the annual education issue of the *Journal of the American Medical Association.*

The housestaff policy survey, the income and expense survey for university-owned hospitals, and the executive salary survey are the recurring surveys that provide information on teaching hositals.

In addition to the major information systems of the Association a number of specialized systems continue to be developed and improved. These specialized systems support the activities of the Council of Teaching Hospitals, the Group on Business Affairs, the Group on Institutional Planning, the Group on Medical Education, the Council of Academic Societies, the chief undergraduate health profession advisors, the women in medicine program, and legislative affairs activities. Mailing labels, individualized correspondence, and laser-produced photocomposed directories are examples of the services provided. Expansion and extensive revision of the Association's membership system continues as a major project. When completed, this system will integrate the services provided in many of the specialized systems and will continue to produce labels for the *Weekly Activities Report* and for the *Journal of Medical Education.*

Data collection, rapid processing, and timely dissemination of information gathered from its members and independent constituents continue to be major objectives of the Association. The focus on information important to medical education that assists the members in the decision-making process is the prime thrust of the Association's information systems.

Treasurer's Report

The Association's Audit Committee met on September 7, 1983 and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1983. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 22, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $11,627,154. Of that amount $10,696,362 (92%) originated from general fund sources; $376,004 (3%) from foundation grants; $554,788 (5%) from federal government reimbursement contracts.

Expenses for the year totaled $10,125,955 of which $9,076,543 (90%) was chargeable to the continuing activities of the Association; $494,624 (5%) to foundation grants; $554,788 (5%) to federal cost reimbursement contracts. Investment in fixed assets (net of depreciation) decreased $241,028 as a result of a decision by the Executive Council to raise the ceiling for capitalization of fixed assets from $500 to $2,000.

Balances in funds restricted by the grantor decreased $62,963 to $499,661. After making provisions for reserves in the amount of $875,000 principally for student data base conversion, the clinical evaluation project, MCAT and AMCAS development, purchase of computer equipment and the MCAT essay and diagnostic services program, unrestricted funds available for general purposes increased $706,534 to $8,239,850, an amount equal to 81% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100% of the Association's total annual budget. It is of continuing importance that an adequate reserve be maintained.

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
BALANCE SHEET
June 30, 1983

ASSETS

Cash		$ 13,437
Investments		
Certificates of Deposit		14,381,896
Accounts Receivable		1,004,923
Deposits and Prepaid Items		128,666
Equipment (Net of Depreciation)		913,973
TOTAL ASSETS		16,442,895

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		$ 1,330,466
Deferred Income		1,456,800
Fund Balances		
Funds Restricted by Grantor for Special Purposes		499,661
General Funds		
Funds Restricted for Plant Investment	$ 496,856	
Funds Restricted by Executive Council for Special Purposes	3,505,289	
Investment in Fixed Assets	913,973	
General Purposes Fund	8,239,850	13,155,968
TOTAL LIABILITIES AND FUND BALANCES		$16,442,895

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
OPERATING STATEMENT
Fiscal Year Ended June 30, 1983

SOURCE OF FUNDS

Income	$ 3,008,015
Dues and Service Fees from Members	376,004
Cost Reimbursement Contracts	554,788
Special Services	5,007,514
Journal of Medical Education	100,489
Other Publications	351,735
Sundry (Interest $1,644,586)	2,228,609
TOTAL SOURCE OF FUNDS	$11,627,154

USE OF FUNDS

Operating Expenses	
Salaries and Wages	$4,410,248
Staff Benefits	718,259
Supplies and Services	3,815,386
Provision for Depreciation	290,555
Travel and Meetings	883,615
Loss on Disposal of Fixed Assets	7,469
Interest Expense	423
TOTAL EXPENSES	$10,125,955
Increase in Investment in Fixed Assets (Net of Depreciation) (Decrease)	$ (241,028)
Transfer to Executive Council Reserved Funds for Special Programs	875,000
Reserve for Replacement of Equipment	223,656
Increase in Restricted Fund Balances (Decrease)	(62,963)
Increase in General Purposes Funds	706,534
TOTAL USE OF FUNDS	$11,627,154

AAMC Membership

	1981–82	1982–83
Institutional	123	125
Provisional Institutional	4	2
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	16	18
Academic Societies	73	73
Teaching Hospitals	416	432
Corresponding	331	87
Individual	1300	1174
Distinguished Service	51	62
Emeritus	47	68
Contributing	4	5
Sustaining	12	10

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