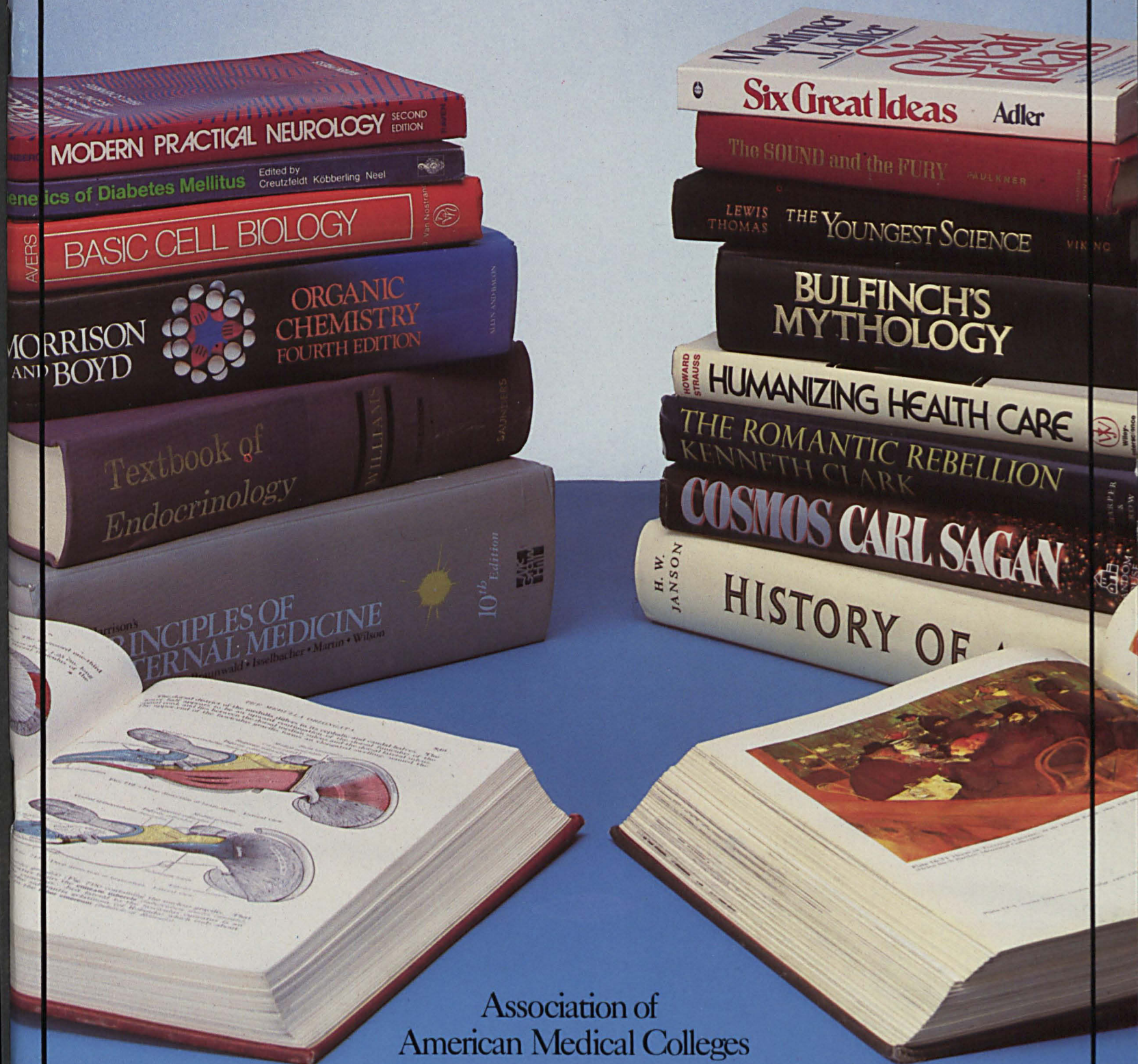


1983-84 ANNUAL REPORT



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American Medical Colleges

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Chairman, Council of Teaching Hospitals

Haynes Rice

1983-84 ANNUAL REPORT

Association of American Medical Colleges
One Dupont Circle
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AMERICAN ASSOCIATION OF
MEDICAL COLLEGE FACULTIES
1100 19th Street, N.W.
Washington, D.C. 20036

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President's Message

The Association of American Medical Colleges has recently received the final report of the Project Panel of the General Professional Education of the Physician and College Preparation for Medicine study. The comprehensive review of undergraduate medical education that this project entailed and the widespread interest generated by the AAMC activities have led many faculties to initiate similar studies in their institutions. Throughout the nation evaluation of the medical education curriculum is being approached with new vigor and a positive environment for change exists. The recommendations of the GPEP report will be the basis for the development of Association policies and programs in the years ahead. The Association sponsored a similar study which was reported in 1932. This earlier effort produced many of the same recommendations made by the GPEP panel. I hope that the interest and excitement generated by GPEP can be translated into productive changes, that my belief in the readiness of the faculties and medical school administrations for change is correct, and that there won't be the need for repeating the same recommendations in another report on medical education fifty years from now.

Medicine today is in the midst of rapid and profound change. This change results from the accelerating rate at which new knowledge is being developed by biomedical research, the rapid incorporation of complex technology into medical practice, demographic shifts occurring in our society, the rate of increase in the cost of medical care, and new approaches to the delivery of medical care. These and other forces impact on some level of medical education and create the need to examine the effectiveness of our programs to prepare physicians to practice in the new environment.

There is a growing consensus that our present approach to medical education may not be the optimal way to prepare students to cope over their professional career with the ever increasing rate at which new information flowing from biomedical research replaces old knowledge. Concerns about the degree of emphasis now given to passive learning in lectures are well founded. The trend towards faculty-centered rather than student-centered instruction is reflected in the progressive growth in lecture hours over the past two decades. This change has been at the expense of small group discussions, independent study, and laboratory exercises. An analysis using the method employed by undergraduate colleges and graduate schools reveals that, on the average, students carry 28 credit hours during each of their first two years of medical school, largely in lecture courses; in some schools they carry as many as 40 hours. This load far exceeds the usual limit of the 16 to 18 credit hours permitted for college students or the 12 to 14 hours allowed graduate students.

Concerns are also developing about the content of the courses and the type of information medical students are required to learn. This has changed with the expansion of basic science faculties that followed their increased involvement in biomedical research. The former practice of assigning a small number of faculty members in a department to organize and present the course for medical students has been replaced by a "parade of stars." In one institution, there are 45 lecturers for a 65 hour lecture course in pharmacology. This institution also finds it necessary to import three participants in the course from other medical schools because they do not believe any of their own faculty are competent to lecture to medical students in three areas of the discipline!

The size of this greatly expanded family of teachers makes it difficult to plan or coordinate the educational program both within and across disciplines. There is also a greater probability that each lecturer will cover the subject matter in exquisite detail, more appropriate for graduate students in the discipline than medical students. The amount of detail presented in all of the courses confuses and disheartens students and makes it more difficult for them to synthesize and correlate information into a meaningful understanding of the subject matter. The increasing density of the trees makes it hard for the student to develop a real appreciation for the beauty of the forest.

Because there is not general awareness of the content of the entire span of a student's formal education, including residency training, each lecturer labors under the perception that recounting what he has learned is the last opportunity to transfer information absolutely essential for the safe practice of medicine from his head into the student's head.

The time devoted to lectures leaves little time for developing the student's interest and ability to learn independently. This skill is becoming more important for physicians if they are to practice modern medicine throughout their professional careers. Today, the factual information carried away from medical school and residency training serves physicians for a shorter period than in the past when the pace of discovery was much slower. New knowledge is replacing old knowledge more rapidly; traditional continuing education courses cannot replace the physician's own interest and ability to keep up with those aspects of medicine relevant to his practice.

There is growing appreciation of the role of computers in information management and the reduction of the amount of factual knowledge that must be committed to memory. Computers can also play an important role in helping students master problem solving. They are patient tutors that provide the opportunity for students to practice their skills until they have been mastered.

There is also the recognition that faculties may not be as ready for the coming "computer revolution" in education as their students. They must become more comfortable with the new technology and convinced of contributions it can make before they will use it widely.

Questions are being raised about the methods for evaluating students. There is a feeling that multiple-choice examinations, epitomized by the National Board examination, reinforce the emphasis on memorization of detailed facts. Although these tests may be easier to grade and appear to be more objective, they are limited in scope. They largely measure the ability of an individual to respond to cues and distinguish between very similar answers. However, they do not provide information on a student's ability to conceptualize a problem, to draw from his store of knowledge, to organize his thoughts logically and to express them clearly in good English. Even though they may be less reliable, essay examinations, especially open book, and oral examinations give a clear message from the faculty of their real interest in qualities and achievements of students beyond the capacity to learn factual knowledge.

Criticisms of the general professional education of the physician are not limited to the preclinical years of medical school. In contrast to complaints about the rigidity in organization and overcrowding of the curriculum in the first two years, the clinical experiences are often viewed as too permissive, poorly integrated, and inadequately supervised by the faculty. The knowledge and skills which the students are expected to acquire are poorly defined and the competence of the student is inadequately evaluated. In particular, students are infrequently observed and monitored in their performance of the basic elements of the case method for teaching clinical medicine by the faculty. As a result there is inadequate feedback to students about their strengths and the areas of weakness that need attention.

Clinical faculties do not differentiate sufficiently between the level of their expectations for medical students and residents. There appears to be an incorrect impression abroad that medical students should achieve a level of clinical education and training only somewhat less than is required of those finishing residency training. Medical students more properly should be provided an opportunity to develop a broad understanding of medicine and acquire a defined set of clinical skills. However, these goals are somewhat at odds with the desires of the house officers that the medical students become intimately involved in and responsible for daily patient care and carry out routine procedures on the service. These demands often compromise the students' ability to perform detailed patient workups, read extensively in the current literature about their patients, learn the basic knowledge of medicine, and meet the expectations of the clinical faculty.

Problems arise when much of the responsibility for the clinical clerkships is left to the resident staff with little or irregular involvement of the faculty. As a result, students are not presented often enough with the role model of a mature clinician who can not only set the example of an experienced clinician but can also demonstrate and demand empathy and concern for the patient as an individual rather than a "case."

Providing clinical education and training for medical students is also made more difficult by the high degree of specialization of the attending staffs and clinical services in teaching hospitals. This is not the ideal environment for an introduction to clinical medicine. On the other hand, the use of less sophisticated clinical facilities is not an easy undertaking because of the heterogeneity in the hospitals and the variability of the teaching interests and capabilities of their staffs.

There have been attempts to overcome some of these problems by establishing general, introductory clerkships in the principal teaching hospitals under the direction of selected members of the faculty using patients from multiple clinical services. The goal is to provide resources more appropriate for the experience of medical students in clinical clerkships within an institution organized along specialty lines. The object is to provide a better mix of patients for the students and to establish a better balance between service and education. Other variations of this approach have been tried but the general clerkship has not spread very widely. It requires a dedicated faculty and a willingness to accept a second organizational pattern within the teaching hospital. All in all, I believe that we have not been very successful in creating a clinical environment that really meets the needs of undergraduate medical education, but we have tried hard to make the best of a highly specialized facility for this purpose.

The growth of high technology in medical practice is most evident in the tertiary teaching hospital. Although technology is important for residency training for a specialty, the involvement of medical students with this complex instrumentation must be tempered by their need for training in the simpler fundamentals of medical care.

The completely elective senior year, which the students use as an opportunity to select subspecialty clinical rotations is coming under more scrutiny by the medical school faculties. It has brought about the compression and crowding of the educational core into three years. It has also become a time when the student travels to other institutions for elective clerkships chosen more to impress residency selection committees than to complete the general professional education of a physician. The desire for program directors to gain first hand knowledge of those they are considering for residency training makes it difficult for students not to respond, particularly as the number of first year places in graduate medical education approaches the number of U.S. graduates. For these and other reasons, one senses a move to impose required or selective clerkships and to reduce the freedom of students to use the senior year as they see fit.

The graying of America creates another imperative for medical education. More attention is required to the consequences of aging, the peculiarities of acute disease in the elderly, the management of multiple, chronic diseases, and the importance to the elderly of caring by the physician. Students now in medical school and residents in training will be at the peak of their practice in the year 2010, when it is estimated that 75 percent of the efforts of physicians will be directed to those over 65 years of age. The Association has prepared guidelines for the faculty to use in reviewing the medical education programs in the institution for their adequacy in preparing students to respond to this changing demography. It appears that these have been well received.

Growing concerns about the rate of increase in the costs of medical care require that greater effort be made to sensitize students to costs. Clinical education must stress more thoughtful and parsimonious use of resources in the care of patients with particular attention to length of stay and the use of ancillary services. Students should develop an understanding of our system of medical care and changes being introduced in reimbursement mechanisms, new organizational modalities such as health maintenance organizations and preferred provider plans, and the consequences of abandoning the traditional view that medical care is a social service and replacing it with the concept that it is an industry that carries on strategic planning, identifies and markets products, and uses very creative corporate restructuring to permit the operation of multiple, often for-profit, businesses. Students should also gain an appreciation for the increasing problem we face in maintaining access for those from all socioeconomic levels of society to high quality medicine in this new environment.

Making these changes will involve costs at a time of financial stringency, and require some fundamental alterations in some of the faculties' priorities. The faculty will have to devote a greater amount of their effort in medical education. If this is to come about there will have to be greater recognition of teaching through rank, salary and space, which are the measures of status in a medical school. It will be difficult to divert faculty time from research through which they establish their reputation with their colleagues—locally, nationally and internationally. In addition, any decrease in contributions from outside support for research or the income generated by the clinical faculty through the medical service plan as a result of the greater effort in teaching would pose real problems for institutions already facing fiscal problems and may constitute a real impediment at many medical schools for any change in faculty effort.

Joseph St. Geme, Jr., professor of pediatrics at UCLA, provided a clear statement of the reason that we should devote our efforts to make the necessary modifications in our educational programs. He observed that "The most compelling consequence . . . will be the restoration of a sense of joy and enthusiasm of our medical students for the excitement, wonder and future of the biomedical sciences and clinical medicine . . ."

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

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 year. Constituent participation in the General Professional Education of the Physician project was discussed, and the 1984 annual meeting program was planned to explore some of the challenges to medical education which were considered during the GPEP project. The Association's new student and applicant information management system was described and areas for potential research and study identified. Several aspects of graduate medical education were discussed including the appointment of residents in the second postgraduate year, institutional responsibility for graduate medical education, the national accountability of certifying boards in decisions affecting the resources required for graduate training, and relationships between medical schools and Veterans Administration hospitals. Since the congressional calendar for the coming year included NIH authorization legislation, the retreat participants considered appropriate Association legislative strategy. Another concern related to the desirability of involving medical school practice plans in the Association and in the academic mission of medical schools. The COTH Board had developed an issues paper for that Council and a draft version was presented for retreat consideration. Participants felt that similar papers should be developed by the other Councils so that all aspects of the Association's programs could be reviewed by the governance structure. Other issues discussed included the Association's relations with other

organizations, COTH membership criteria, and Medicare reimbursement.

Many of the issues reviewed and debated by the Executive Council during the past year were concerned with graduate medical education. The Council had discussed problems associated with the appointment of medical students and graduates into specialty programs in the second postgraduate year. The current system places an undue burden on students to make early career decisions, requires dean's letters to be written before critical evaluations are available, and does not provide the most logical educational sequence for students. The Executive Committee met with representatives of those specialties to discuss their concerns and to better understand the needs of the specialties. Participants at that meeting endorsed a proposal that the National Resident Matching Program establish an advisory panel of program directors from each of the specialties. There was also agreement that a productive dialogue had been initiated and should be continued.

Of particular concern to the Executive Council was action by the American Board of Pathology to lengthen training requirements for certification in that specialty. The Executive Council opposed this action since it was felt that the Board had acted without considering the opinions of the educational institutions and other programs which must provide the resources for the additional year of training. That other certifying boards were also considering such decisions without widespread discussions within the academic community heightened the Council's concern and led to its statement of formal opposition to the action by the pathology board. As a member of the American Board of Medical Specialties, the AAMC introduced an amendment to the ABMS bylaws to require such decisions to be discussed by ABMS and concerned specialties before implementation.

TEFRA and the Medicare prospective payment system have revised reimbursement policies significantly. With these changes has come renewed discussion of the appropriate payment mechanism for graduate medical education. To assure that the views of the Association's constituents are considered in such discussions, the

Executive Council has established a new AAMC committee on financing graduate medical education. To begin the committee's deliberations, a special joint session of the administrative boards was held in September 1984 to review ongoing studies, to discuss alternative financing mechanisms, and to engage the governance structure and the committee in a review of these issues. The Association also commissioned a paper by Judith Lave on the historical development and future prospect of the indirect medical education adjustment under the Medicare prospective payment system.

The Association approved the Special Requirements for the Transitional Year of the Accreditation Council for Graduate Medical Education.

Research and research training continue to be important priorities of the Association, and much Executive Council attention has been devoted to such issues. The Council's "Principles for the Support of Biomedical Research" has been the cornerstone of Association policy in this area, and has been widely distributed to other organizations and policy-makers.

The Council reviewed a number of studies on the status of research facilities and instrumentation and endorsed such efforts to document the research needs of universities and medical schools. The Council supported the objectives of the University Research Capacity Restoration Act of 1984 and discussed changes to the legislation that would alleviate Council concerns with the treatment of NIH.

Methods of financing the construction of research facilities were discussed and support was given for a new matching grant program for this purpose. The Council also discussed how faculty salaries are charged to grants and contracts; it was agreed that the Association would continue to provide information to its constituents in this area.

A major research issue that continued throughout the year concerned the use of animals in biomedical research. The proposed revisions to the Public Health Service animal welfare policy were reviewed and several problems with the revisions identified. The Council strongly recommended that Association constituents be urged to participate in education efforts on the use of animals in research, and that such educational efforts be conducted on the local as well as national level.

The Institute of Medicine of the National Academy of Sciences was studying the organizational structure of the National Institutes of Health. The Council endorsed an Association submission to that study's steering committee. The AAMC statement recommended program selection and project funding based on scientific promise and quality, congressional reliance on general authorities rather than detailed statutory prescriptions

for NIH, ten-year reviews of the organizational structure of NIH for reaffirmation or revision, strengthening of the office of the NIH Director, and establishment of a forum at NIH in which advocates of programs could present their views and learn of NIH efforts in their areas of interest.

Discussions at the COD and COTH spring meetings on relationships between some of the Association's constituents and investor-owned organizations had resulted in a survey on medical school contacts with for-profit organizations. It was agreed that the Association would continue to monitor such activity, but that because of the diverse and strongly held opinions of its constituents, no action to change membership policies would be taken at present.

A new program of faculty development will be sponsored by the Association. With the co-sponsorship of the American Council on Education, a National Identification Project Forum for Women will be held in February 1985 to foster professional advancement for women into senior positions in medical center administration.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees. The final report of the General Professional Education of the Physician and College Preparation for Medicine study was received by the Executive Council and will serve as the basis for new Association policies and programs in the years ahead.

The final report of the ad hoc Committee on Capital Payments for Hospitals was also presented. The Council endorsed a policy that would allow institutions to choose either cost reimbursement for depreciation and interest or a prospective capital add-on. This committee was chaired by Robert Frank, president of Barnes Hospital.

The Executive Council continued to oversee the activities of the Group on Business Affairs, the Group on Institutional Planning, the Group on Student Affairs, the Group on Public Affairs, and the Group on Medical Education.

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 1985.

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 Assistant Secretary for Health Edward Brandt. They also met with the Executive Committee of the Association of Academic Health Centers to discuss issues of mutual concern.

THE COUNCILS

COUNCIL OF DEANS

The Council of Deans activities in 1983-84 were dominated by its two major meetings—the business meeting at the Association's annual meeting in Washington, D.C. and the spring meeting in Pine Mountain, Georgia. During the interim the Council's Administrative Board met quarterly to review Executive Council agenda items of significant interest to the deans and to carry on the business of the COD. More specific concerns were reviewed by sections of deans brought together by common interests.

At the program session of the annual business meeting, William H. Luginbuhl, dean, University of Vermont School of Medicine, gave the feature presentation on health care cost containment. Discussions at the business meeting centered on commercial sponsorship of medical education programs, problems associated with federal intervention in decisions on the medical treatment of severely handicapped infants, and the management and reimbursement of the indirect costs of research. Two resolutions were adopted by the Council. The first expressed concern that the poll conducted in conjunction with the project examining undergraduate medical education (GPEP) prevented the expression of important views by the deans; the second was a resolution expressing appreciation to the AAMC president for his inspirational address opening the meeting.

Ninety-two deans attended the annual spring meeting April 1-4th. Richard Schmidt, president, SUNY-Upstate Medical Center, began the first session with a discussion of the need for adequate house officer supervision. Ronald P. Kaufman, vice president for medical affairs and executive dean, George Washington School of Medicine and Health Services, explored medical school relations with a for-profit hospital. Jerome H. Grossman, president, New England Medical Center, reviewed challenges to medical school/teaching hospital relationships brought about by changing demographics and new methods of reimbursement for medical services. An industrialist's perspective on medical care cost containment was provided by J. Paul Sticht, chairman, R.J. Reynolds Industries, Inc. Baruch A. Brody, director, Center for Ethics, Medicine, and Public Issues, Baylor College of Medicine and H. Tristram Engelhardt, professor, department of medicine and community medicine, Baylor College of Medicine, presented ethical issues in a medical system designed to be price sensitive. The second day was devoted to undergraduate medical education. Sherman Mellinkoff, dean, University of California, Los Angeles, School of Medicine, discussed educating students in the clinical disciplines. He was followed by

Robert L. Hill, chairman, department of biochemistry, Duke University School of Medicine, on educating students in the basic science disciplines. The presentations stimulated discussion among the deans on issues bearing directly on their responsibilities as educators.

The spring meeting was preceded by an orientation session for new deans that introduced the AAMC leadership and staff, and provided an overview of the resources and programs of the AAMC. At the spring business meeting, the Council discussed methods by which its membership could develop a greater sense of access to and influence on AAMC decision-making. Board members and committee chairmen commented on their own perceptions of effective channels of communication. The Council recommended revisions in the Council of Deans' roster to enhance its utility. Also considered were the draft "LCME Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree," medical education and international relations, the national earthquake conference, the AAMC clinical evaluation program, and a COD issues identification paper which outlined the issues facing medical school deans and their implications for the COD as a constituent part of the Association and for the AAMC itself.

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.

The Council endorsed its chairman's proposal that the annual meeting include additional events and meetings targeted to the needs and interests of the deans. This new format will provide more participation for deans in discussions on issues and will alleviate the concerns expressed at the spring meeting.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies is comprised of 76 academic societies representing U.S. medical school faculty members and others from the basic and clinical science disciplines. The Council convened two meetings during 1983-84.

The CAS meeting at the 1983 AAMC annual meeting addressed "Research Support: A Consensus Is Needed." A series of speakers addressed concerns that in an era of diminishing resources, advocacy for disease and program-specific interests within the overall program for biomedical and behavioral research resulted in fragmentation of research effort and funding rather than an increase

in resources. Speakers included William F. Raub, associate director for extramural research, NIH, who spoke on "Research Funding Priorities of the National Institutes of Health," John F. Sherman, vice president, AAMC, who enunciated the AAMC's position on "Principles for the Support of Biomedical Research," John Walsh, reporter for *Science*, who discussed "Congressional 'Micro-management' of the NIH," Leonard Heller, vice chancellor for academic affairs, University of Kentucky Medical Center, who reviewed "The Science of Politics and the Politics of Science," and Sherman M. Mellinkoff, dean of the University of California, Los Angeles School of Medicine, addressing the question "Can Biomedical Research Survive Attacks of Confused Lucidity?"

The Council's annual spring meeting was held in Washington, D.C. April 10-11, 1984. Representatives of the societies participated in a plenary session and workshops to identify and explore the "Issues and Challenges Facing Medical Faculty in the Next Five Years." In his keynote address Kern Wildenthal, dean of the University of Texas, Southwestern School of Medicine, addressed the challenges raised by the multiple roles and duties confronting an individual faculty member including competing disciplinary and institutional demands. Council members then were addressed by speakers who articulated the issues and challenges facing faculty in each of their three traditional roles in education, research and patient care.

Victor Neufeld, chairman of the M.D. program at McMaster University and a member of the Panel on the General Professional Education of the Physician, addressed the explosive growth of knowledge, the increase in institutional complexity and changing patterns of health care delivery. Ronald Estabrook, professor of biochemistry at the University of Texas, Southwestern School of Medicine, concluded there was concern for continued appropriation of research funds and their effective distribution, for appropriate training programs for future research faculty, and for the need to modernize university research equipment and facilities.

Kenneth Shine, chairman of medicine at UCLA, noted that an era characterized by a dramatic increase in access to health care has been followed by an era emphasizing cost containment in care delivery. Faculties are challenged to provide high quality health care and clinical education within such a setting. Edward Stemmler, dean at the University of Pennsylvania School of Medicine, stressed that this was a critical time for faculty to participate in governance and to concern themselves with clarifying and affirming their missions so that they would be prepared to assist in the formulation of major policies at their institutions.

After workshops further discussed these challenges, the CAS concluded by considering the role it might play in meeting these challenges. The deliberations at the spring meeting will form the basis of an issues paper reviewing the challenges and strategies for meeting them which will be considered at the next annual meeting.

The CAS Administrative Board conducts its business at quarterly meetings held prior to each Executive Council meeting. In April the Administrative Board undertook a thorough examination of the growing concern about the deteriorating condition of institutional research facilities and instrumentation. Guest speakers included Helen H. Gee, chief of the program evaluation branch of the office of the director, NIH, John C. Crowley, the director of federal relations for science, Association of American Universities, and Carol R. Scheman, director of federal relations for health and biomedical research, AAU. The Board reviewed a series of studies currently underway to document and quantify the need for major new investment in the physical plant at research institutions. Discussion centered both on the perceived deterioration in the research infrastructure and on proposed and contemplated policies to remedy such deterioration.

At its June meeting, the CAS and COD Administrative Boards met jointly to discuss attempts to restrict the use of animals in research. A brief resume was provided of current bills before Congress and there was discussion of the recent attack on the laboratory of a research scientist at the University of Pennsylvania School of Medicine and theft of records of long term research projects. A successful effort to educate the public and state legislature in California concerning the threat to research implicit in a bill to restrict the use of pound animals was analyzed. Members were made aware of a national effort by societies most concerned with the use of animals in research to form a working group which could undertake a more concerted effort to deal with legislative, regulatory or public pressure threats to limit the use of animals in research.

The Association's CAS Services Program continues activities of their society. Six societies participated in the program in 1983-84: the American Federation for Clinical Research, the Association of Professors of Medicine, the American Academy of Neurology, the American Neurological Association, the Association of University Professors of Neurology and the Child Neurology Society.

THE COUNCILS

COUNCIL OF TEACHING HOSPITALS

Two general membership meetings highlighted the activities of the Council of Teaching Hospitals in 1983-84. On November 7th the COTH General Session, held annually as part of the AAMC annual meeting, addressed "Moral Dilemmas and Economic Realities." Laurence B. McCullough, associate professor of community and family medicine and senior research scholar at the Kennedy Institute of Ethics of Georgetown University, discussed the role of hospital administrators in ethical problems facing the medical community. He stressed the need for clarity of reasoning, rigor and consistency in reaching the resolution of a problem, and developing the appreciation of and tolerance for the ongoing challenge to balance the demands of conflicting moral principles and the obligations they generate. James Bartlett of Strong Memorial Hospital and Charles O'Brien of Georgetown University Hospital responded to Dr. McCullough's remarks, raising questions regarding ethical behavior and moral dilemmas facing teaching hospital chief executive officers.

Senator David Durenberger was the keynote speaker for the 7th COTH spring meeting held May 16-18 in Baltimore. The Senator reiterated his position favoring competition and consumer choice in the health care marketplace, although he recognized that such competition could place teaching hospitals in a difficult position. To provide a more equitable, competitive environment for teaching hospitals, Durenberger indicated his interest in developing a state block grant program to finance graduate medical education.

Two main themes carried the meeting: changes to the teaching hospital organization and environment, and the relationship of investor-owned corporations to the teaching hospital. Robert W. Crandall, senior fellow, the Brookings Institution, described the restructuring of a variety of marketplaces to emphasize competition in other industries. Observing that entrepreneurial activity was the key to development of competition in other industries, Crandall believes hospitals must develop more entrepreneurial activities in their new marketplace. Karl D. Bays, chairman of the board, the American Hospital Supply Corporation, described the conflicting signals being received in the re-regulated marketplace, including competition, use of waivers, rate setting, access to care, business coalitions and the attitude of the general public. The need for a more efficient system was repeatedly emphasized. The alternative to efficiency, Bays said, is more federal control and perhaps second rate medical care.

Addressing the problem of paying for charity care, Lawrence Lewin, president of Lewin and

Associates, demonstrated that appropriate policy responses require identifying characteristics both of individuals unable to pay for services and of hospitals providing the care. He noted that the problem is most acute in public teaching hospitals located in large cities. James Isbister, senior vice president, federal programs, Blue Cross and Blue Shield, described changes in consumer choice of insurance coverage based primarily on level of premium. Gordon Derzon, superintendent, the University of Wisconsin Hospital and Clinics, and Robert Zelten, associate professor, the Wharton School, each discussed operating changes necessary to compete in the new environment. Derzon emphasized that restructuring for pre-paid health care with its assumption of provider risk should be an objective of the teaching hospital. Zelten described the options available for hospitals ranging from simply supplying services to organizing and underwriting of health programs.

Judith R. Lave, professor of health economics, the University of Pittsburgh, reviewed the historical development and future prospects of the indirect medical education adjustment under the Medicare prospective payment system. James Bentley of the AAMC made observations about the impact of the prospective payment system on COTH members from the preliminary results of an AAMC survey.

Three speakers presented case studies exploring the relationship of investor-owned corporations to the teaching hospital. They were Ronald P. Kaufman, vice president for medical affairs and executive dean, George Washington University Medical Center, Donald P. Kmetz, vice president for hospital affairs and dean, University of Louisville School of Medicine, and J. Robert Buchanan, general director of the Massachusetts General Hospital.

AAMC staff member Richard Knapp presented the discussion paper "New Challenges for the Council of Teaching Hospitals and the AAMC Department of Teaching Hospitals." The meeting concluded with a spirited discussion of the possible inclusion of investor-owned hospitals in COTH.

The Administrative Board of the Council of Teaching Hospitals met four times to conduct business and discuss issues of interest and importance. Substantial attention was devoted to the Medicare prospective payment system and its effects on teaching hospitals. A survey instrument to determine the impact of the new payment system was reviewed and approved. Other topics at the COTH Board meetings included new JCAH requirements, resident supervision in teaching hospitals, and participation of investor-owned hospitals in COTH. The Board asked that the COTH membership express its views on the latter

issue at the next Council business meeting.

Under the guidance of the COTH Administrative Board, AAMC staff prepared "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." Outlined in the paper are major trends facing teaching hospitals and managerial needs receiving increased attention. The paper describes the environment for the Council of Teaching Hospitals, the growth in hospital organizations competing for national attention, and the members of the Council. The discussion paper was sent to all AAMC constituents for review and comment.

ORGANIZATION OF STUDENT REPRESENTATIVES

Again this year 123 medical schools designated a student representative to the AAMC. Approximately 155 students from 98 schools attended the 1983 Organization of Student Representatives annual meeting. The first program was sponsored jointly with the Society for Health and Human Values on "Ethical Dilemmas of Medical Students: Questions No One Asks." Observations on ethical conflicts confronting third and fourth year students were offered by Joanne Lynn, a practicing physician; Kathryn Hunter, assistant professor of humanities in medicine, University of Rochester Medical Center; Brent Williams, resident in internal medicine, University of Virginia; and Louis Borgenicht, assistant professor family and community medicine, University of Utah School of Medicine. Then Society and OSR members held small group discussions on ethical cases prepared by the OSR Administrative Board. On Saturday afternoon, Hilliard Jason and Jane Westberg of the National Center for Faculty Development in Miami presented a session on "Becoming an Effective Clinical Teacher—For Yourself, Your Patients and Others," followed by teaching skills discussion groups. Two programs offered on Monday afternoon were "Computers and Medical Students: A Hands-On Workshop"

by Lisa Leidan, research assistant, University of Arizona College of Medicine and "Retaining Your Humanism in the Face of Technologic Explosion" by Robert Lang and Alan Kliger, both associate professors of medicine at Yale University School of Medicine. In addition to attending regional and business meetings, which included a presentation from Wesley Clark, a member of the professional staff of Senator Edward Kennedy, OSR members identified a series of issues important to students. Plans were formulated by small groups for addressing the following issues during the year: ethical responsibilities of medical students, student financial aid, housestaff concerns, developing teaching skills, career decision issues, highlighting the social responsibilities of physicians, and curricular innovations.

At its four meetings during the year, the Board considered many of the Executive Council's agenda items, shared information on regional OSR projects including the spring meetings, and discussed updates provided by staff on the addition of an experimental essay to the MCAT, the need to educate medical students about the role of animals in research, renewal of health manpower legislation, and financial aid program updates. Two Administrative Board projects underway are a compendium of residency interview travel tips to assist fourth-year students to economize and plan efficiently and ethical guidelines for medical students during the clinical years.

Two issues of *OSR Report* were distributed to medical students. The Spring 1984 issue, "Ethical Responsibility and the Medical Student: Setting Personal and Professional Goals," included guidelines for traversing the path from perceiving a moral dilemma to acting on it and probed dilemmas physicians face. The Fall 1984 issue, "Economic Changes Affecting Medical Practice: What Do Medical Students Need To Know?" described the ongoing revolution in health care financing. It also offered students advice on coming to terms with new limitations on the use of medical resources and on physicians' autonomy.

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Events during the twelve months since the last national policy review have increasingly come under the influence of presidential election year politics. Of those legislative and regulatory issues in which the academic medical community has an interest, many that the Association perceives as of the highest public benefit have languished, while other legislation has acquired unexpected momentum. Whatever the merit of much of the activity on the national scene over the past year, there is general agreement that the impending presidential election has made it an extremely busy one.

This was the year to insure recommitment to a major national policy decision taken in 1963 when the Congress initiated direct support to medical education. Authorities in Title VII of the Public Health Service Act for health professions educational assistance were expiring and the AAMC testified for their renewal before the Senate Labor and Human Resources Committee. Since no bill had been introduced, the Association generally advocated simple extension of current law with generous authorization ceilings, stressing the need for federal support of student financial assistance and targeted educational initiatives.

Senate health manpower legislation (S. 2559) was eventually introduced in April by Senator Orrin Hatch, while Senator Edward Kennedy circulated an alternative bill. The eventual compromise proposed a four-year reauthorization of all programs of interest to the AAMC. Unfortunately, except for the Health Professions Student Loan and the Disadvantaged Assistance programs, the authorization ceilings only slightly exceeded FY 1984 appropriations. Authority for equipment and instrumentation grants was added. Modifications of the HPSL program would: allow the IRS to release to institutions the present addresses of borrowers whose loans are in default; give HHS the authority to collect on defaulted loans; allow insurance premiums to be charged to cover losses for borrower death and disability; and direct all new capital contributions to schools that entered the program after July 1, 1972. Apparently persuaded by predictions of a high default rate for HEAL loans, the Senate empowered HHS to raise insurance premiums from 2 to 6 percent. In addition,

HHS would be required to study financial disincentives in certain physician specialty and practice location choices and to recommend legislative solutions. This proposal cleared the full Senate in late June.

A companion bill, S. 2281, to continue the National Health Service Corps and to authorize 150 new NHSC scholarships annually was reported in late March. The bill requires a long-term staffing plan for the Corps and combines two private practice loan option loan authorities. The AAMC has long felt that as the national supply of physicians increases, the need for a NHSC diminishes. The NHSC scholarship program, with its high unit costs, has been traditionally justified on the basis of the field program needs. To the extent that the need for the Corps is fading, so too is that for the scholarship program. The amount of money now expended on NHSC scholarships could be used more effectively in other student financial assistance programs. Nevertheless, the Senate subsequently passed the NHSC and the NHSC scholarship programs without amendment.

The AAMC also testified at a House Subcommittee on Health and the Environment hearing in late April on the renewal of Title VII authorities, although no bill had been introduced. The Association's position was essentially the same as in the Senate, but called particular attention to the deleterious effects of underfunding of the Health Professions Student Loan and Exceptional Financial Need Scholarship programs and the urgency of alleviating the burden of the debts accumulated by medical graduates. Other items on the Association's priority list were geriatric education, computer applications to medical information management, and the growing problems of deterioration of the capital plant for medical education. A House bill, H.R. 5602, was reported by the Energy and Commerce Committee in early May. It provided generous authorization ceilings for almost all the programs endorsed by the AAMC. However, a full Committee amendment to ensure bi-partisan support reduced the authorization from four to two years. Some members felt that in view of the predictions of an oversupply of physicians, a more frequent reexamination of the continuing need for

these programs was warranted. H.R. 5602 also reauthorized the NHSC programs, maintaining the field program at higher levels than allowed for in the Senate bill and providing 550 new scholarships each year.

Medical students also use assistance programs authorized in Title IV of the Higher Education Act. A bill (H.R. 4350) to reauthorize that student loan consolidation authority passed the House in November. The proposal granted consolidation authority to banks as well as to the Student Loan Marketing Association, shortened the repayment period of consolidated loans to 15 years, and raised the loan interest rate to nine percent. The Senate bill introduced in April contained an "ability to pay" provision requiring loan consolidation recipients to undergo a two-tiered "needs" test, and included a nine percent interest rate on the consolidated loans, except where a PLUS/ALAS loan superseded. The bill was reported from the Senate Labor and Human Resources Committee in early May. The principal matters at issue in any conference are the "needs" tests and the propriety of extending consolidation authority to state loan guarantee agencies.

President Reagan's release on February 1 of his budget request for FY 1985 initiated the increasingly complex and progressively more political annual cycle of events leading to the determination of the level of expenditures and revenues for the next fiscal year. In each succeeding year the process seems to become more divergent from that prescribed in the Budget and Impoundment Act. This year, the budget resolutions and reconciliation instructions to set ceilings on appropriations levels and to suggest legislative approaches to achieve required compliance with the expenditure ceilings were embodied in unusual vehicles: the Tax Reform Act of 1984; and separate, differing and unconfereed Senate and House budget resolutions.

As a result of explicit expenditure reductions and the net increase in taxes, the Tax Reform Act of 1984 provides that a \$63 billion "down payment" on the deficit be made over the period FY 1985-FY 1987. Among the provisions to accomplish this are: Medicare expenditure reductions totaling nearly \$8 billion, Medicaid expenditure increases of about \$400 million, removal of tax exemption on tuition assistance to employees, except when the courses are related to the employee's job, limitation on the use of tax exempt state bonds and possibly on the availability of capital for the Guaranteed Student Loan program, exemption from taxation of tuition remission for college employees only if the benefit is offered on a non-discriminatory basis, and tax exclusion for the loans forgiven or cancelled by govern-

ment entities when the borrower provides professional services required by the lender.

Not included in the compromise tax bill was a Senate proposal to renew and expand the scope of the 25 percent investment tax credit provided to corporations for research investments. Authorization for the tax credit does not expire until the end of 1985, but the Senate version of the tax bill made it permanent. AAMC had supported the tax credit in the general belief that it would stimulate industrial support of research, including that in academic settings, and because pressure to reduce the federal budget deficit by restricting "tax expenditures" is likely to make enactment in 1985 even more difficult.

Further contributions to deficit reduction were included in the budget resolutions passed by the House and Senate. The House version instructed its committees to achieve a total 3-year savings of \$182 billion by reducing discretionary expenditures. On the Senate side, the budget resolution called for 3-year savings of \$140 billion.

One of the truly bright spots this year has been the outcome of the work of the Appropriations Committees. The AAMC was encouraged by the determination of the Congress to pass a fiscal year 1985 appropriations measure for Labor/HHS/Education, coming, as it did, on the heels of the substantial increases for the NIH in the FY84 appropriations act. It should also be noted that the enactment of appropriations legislation in FY 1984 had broken the four-year trend of funding through continuing resolutions.

President Reagan sought only an \$89 million (two percent) increase in the NIH budget over expected FY 1984 expenditures. The House and Senate Appropriations Committees, in accord with an historical trend toward approving medical research appropriations substantially above the president's budget request, recommended levels for the NIH of \$4,834.3 million and \$4,932.6 million respectively, as opposed to the President's request of \$4,567 million. These congressional figures are all the more impressive because, unlike the level proposed by the president, they do not include unauthorized programs (research training, medical library assistance, etc.; cancer control is also excluded from the House figure).

The congressional increases in the NIH budget responded in large part to the importunings of the Ad Hoc Group for Medical Research Funding. This broad coalition of more than 150 health and medical organizations has attempted to persuade the Congress that the level of appropriations for the NIH should be in keeping with the extraordinary scientific opportunities that have been uncovered through research. The Ad Hoc Group's recommendation for the NIH budget for fiscal

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year 1985 was \$5.214 billion, a 16 percent increase over FY 1984. AAMC testimony before both House and Senate appropriations subcommittees supported the Ad Hoc Group's recommendations for the NIH and ADAMHA budgets, stressed the fundamental role of basic scientific research in the conquest of disease, and called attention to the disturbing impact on the research community of the downward trend in NIH's ability to fund approved research proposals.

The president's budget for the research activities of ADAMHA requested \$373 million, an increase of \$17 million or five percent over the FY 1984 level. Virtually all of the gains were in the relatively small programs in drug abuse, alcoholism, and alcohol abuse. By contrast the Ad Hoc Group advocated an increase of \$47 million. The final recommendation by the Senate Committee was for a \$58 million increase and that of the House for one of \$49 million.

The full House ratified its Appropriation Committee's recommendation for Labor/HHS/Education on August 1. The counterpart bill in the Senate has not yet passed.

The critically important partnership between the Veterans Administration and academic medical centers is the basis for the AAMC's keen interest in the medical components of that agency's budget. In his FY 1985 budget request, President Reagan proposed only modest increases for medical care in the VA, but the increased amounts proposed for research were encouraging. The Association urged the Appropriations Committees to increase the medical care budget by at least the projected rate of increase in Medicare costs, advocated parity between the staffing ratios in VA and private sector hospitals, and argued for additional funding for medical research. However, the final appropriation bill added less than one percent to the president's original requests for programs of concern to academic medical centers.

More than a year ago, the House opened debate on H.R. 2350, a lineal descendent of the series of House attempts initiated in early 1980 to radically restructure the statutory base for NIH programs. Among other provisions, this bill renewed the expiring authorities of the NCI, the NHLBI, the National Research Service Awards program, and the Medical Library Assistance program. It also proposed the elimination from Title IV of any basis for reliance on broad general research authority (Section 301), further extensive and far reaching revisions of that title, and detailed prescriptions for the management of NIH, including its advisory apparatus.

After securing an assurance of AAMC support, Representatives James Broyhill and Edward Madigan announced that they would offer a floor

amendment in the form of a substitute for H.R. 2350 that would simply renew expiring authorities. Since its authorization ceilings were identical to those in H.R. 2350, the amendments neutralized funding as an issue of disagreement and thereby focused the debate clearly on the propriety of statutory "micromanagement" of the research programs of the NIH. The apparent partisan polarization on this question disappeared when Representative Richard Shelby joined as a cosponsor of the substitute, on the condition that it be expanded to include authorization of a new program of research centers for health promotion and disease prevention.

Floor debate was interrupted when the Congress adjourned for its summer recess. Immediately thereafter, intense negotiations were undertaken and in November a compromise version of H.R. 2350 emerged. The minority members made clear to the Association that the new proposal represented their best efforts to achieve a simple renewal, and that several new proposals had been kept out of the bill with difficulty and these would be offered by their proponents as floor amendments.

The most significant gain achieved by this revision of H.R. 2350 was a reinstatement in Title IV of the statutory recognition that Section 301 was the primary authority for the research programs of the NIH. In addition, many of the objectionable features that, in the aggregate, constitute micromanagement were deleted. The proponents of simple renewal were unsuccessful in eliminating provisions that order NIH to develop alternatives to the use of animals in biomedical research and to establish guidelines related to animals in research, create a National Institute of Arthritis and Musculoskeletal Diseases and mandate the Director's Advisory Board, with the composition of it as well as of the institutes' advisory councils prescribed to include an expanded number of members selected from fields such as law, public policy, health policy, economics and management, thereby diluting the scientific expertise available.

When floor debate was resumed on the revised bill, three amendments, all opposed by the Association, were adopted. One created a National Institute of Nursing. The others, one offered by Representative William Dannemeyer and another by Representative Rodney Chandler, dealt with fetal research. The basis for the AAMC's objections to the nursing institute centered on the belief that research in nursing was predominantly related to health services and not biomedical in character, and the proposal brought nursing education under the umbrella of the NIH. The AAMC is persuaded that a recently introduced Senate bill, S.2574, which would elevate the current Division

of Nursing within the Health Resources and Services Administration to "Bureau" status, and create a National Center for Nursing Research, is a more reasonable means of providing needed impetus to research in nursing, and providing greater visibility to the profession of nursing at the national level.

The Dannemeyer amendment bans all forms of research on fetuses scheduled for abortion, except in cases where the research is to increase the chances of survival for that fetus; it unnecessarily restricts fetal research activities already sensibly circumscribed by NIH regulations. It also eliminates the "waiver of minimal risk" provision whose retention is highly desirable to permit policymakers to accommodate unexpected research opportunities. The Chandler amendment, intended to nullify the Dannemeyer language, essentially transfers current HHS fetal research regulations, including the waiver provision, into statute. While the NIH regulations are acceptable, the wisdom of codifying them in statute is questionable, particularly in a rapidly changing area of research for which easier adjustment of regulations is more appropriate. The AAMC opposed both the Dannemeyer and Chandler amendments.

The NIH renewal legislation designed by the Senate, S. 773, was reported in May 1983. This proposal made no attempt to recodify Title IV of the PHS Act, postponed legislation on the use of animals until its recommended study of the need for this could be completed by the National Academy of Sciences, and contained a relatively small number of new authorities, directives, administrative reorganizations, and report requirements. It did establish a new arthritis institute and imposed a requirement on the NIH in the prevention of scientific fraud. Action on S. 773 was stalled in controversy over fetal research provisions.

Political pressures to create a separate National Institute for Arthritis and Musculoskeletal Diseases became very heavy in the late spring. Senator Orrin Hatch responded by arranging to bring S. 540, Senator Barry Goldwater's arthritis institute proposal, to the floor under an understanding that only two amendments would be permitted. One would substitute the arthritis institute provisions of S. 773 for those of S. 540; the other would establish in the congressional Office of Technology Assessment a function similar to that assigned the now defunct National and President's Commissions on Ethics in Medicine and Biomedical and Behavioral Research. The modified bill cleared the Senate and was sent to the House in late May.

Almost immediately, the House acted on S. 540 by striking all but the enabling clause and substituting H.R. 2350 for the provisions in the

Senate bill. It then unanimously approved its version of S. 540 and appointed conferees to resolve the differences in the two versions. To date, Senate conferees have not been appointed. A delay in appointing conferees resulted from negotiations on representation of the whole range of Senate interests, including the remaining content of S. 773, on the conference table, and by the Senate's heavy workload.

Legislation reauthorizing two of the major research programs of ADAMHA was rather routinely passed in June by both the House and Senate. The low outyear authorization ceilings, particularly in the Senate bill, for the National Institute of Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism will severely constrain program growth in those areas.

Provisions in both House and Senate versions of NIH renewal legislation reflect growing congressional responsiveness to the continuing importunings of animal welfare and animal rights groups. In addition to these legislative proposals, Senator Robert J. Dole has held hearings on and revised S. 657, his proposal to amend the Animal Welfare Act. His bill is designed to strengthen and improve the current standards for the treatment of animals, but goes far beyond this aim in mandating "institutional animal committees" in all research facilities, costly and unnecessary reporting requirements for research personnel, and establishment of an information service on improved methods of animal experimentation. Representative George Brown has introduced H.R. 5725, a slightly modified version of the Dole bill.

Another legislative response to the animal rights movement is embodied in H.R. 5098, introduced by Representative Robert Torricelli. If enacted, it would affect all federal agencies conducting research involving live animals by requiring that all research proposals, after approval by a federal agency for funding, be reviewed by a National Center for Research Accountability to ensure that the proposal does not duplicate other research completed or in progress. Decisions would be made only after comprehensive literature searches. This bill is seriously at variance with the philosophy and needs of the academic and scientific communities and would be costly.

The reach of animal welfare/animal rights action to influence the Congress has recently expanded to include appropriations legislation. Both House and Senate subcommittee versions of the Department of Defense appropriations bill for FY 1984 originally contained language that would have prohibited the use of the appropriated funds for the purchase of live animals of any type for training students or other personnel in the treatment of wounds produced by any weapon. The Senate

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Appropriations Committee, largely through the efforts of Senator Daniel Inouye, modified the language in its bill by limiting the prohibition to cats and dogs; the AAMC had urged deletion of the restrictive language entirely. In conference, the Senate provision prevailed and the bill was subsequently signed into law. This year the Humane Society of the United States mobilized its membership to write the Congress to urge that the NIH appropriations bills be amended to prohibit expenditure of these funds for the purchase of animals from pounds or shelters.

On the regulatory front, the NIH in early April published a draft proposal to amend its animal care guidelines and scheduled three public hearings. The Association reasserted its fundamental conviction that since there was no evidence of substantial abuse in animal care and use many aspects of the proposed policy were unwarranted. In addition to the modification of its animal care and use guidelines, the NIH also sponsored an open national symposium on scientific and public policy issues related to animals in research.

It is hard to escape the conclusion that the intensity of concern about animals in research, currently manifest by both the national legislature and the NIH, is for the most part a direct response to an extremely well-organized and well-financed animal welfare/animal rights movement. In addition to exerting influence on the national scene, this group has sought to make its viewpoints prevail at state and local levels. Its tactics include: lobbying legislatures, public demonstrations, break-ins, thefts of experimental animals, vandalism of experimental data, and destruction of laboratory equipment and instruments. The tempo of antivivisection protest is steadily mounting. Moreover, with increasing frequency, clarity, and openness, the movement is articulating the total elimination of animal experimentation as its principal objective.

The Association has been increasingly involved as an active participant in the ethical and policy debate generally referred to as the "Baby Doe" problem. In 1982, its parents decided that their infant with Down's Syndrome and esophageal atresia should not be operated upon or parenterally nourished but be allowed to die. A subsequent court decision held that the parents had chosen a reasonable medical option and there was no basis for government intervention to overrule that parental decision. The ensuing public controversy has stimulated action in the executive, legislative and judicial branches of government.

The initial federal intervention was premised on the prohibition in Section 504 of the Rehabilitation Act of 1973 of discrimination against the handicapped. Based on this assumption, the president in

1982 sent out a warning against discrimination, and in March 1983 HHS proposed regulations on the subject. The latter were struck down by a Federal District Court, largely on procedural grounds. However, the regulations were republished in essentially identical form in July after compliance with formal procedural requirements. The draft "Baby Doe" regulations required posting throughout hospitals of notices explaining the prohibition against failing to feed or care for handicapped infants, offered a toll-free number for reporting suspicious cases, involved state child protection agencies as well as federal civil rights agencies in the investigation of cases, required those agencies to establish written procedures for responding to alleged instances of medical neglect, and mandated that agencies provide protective services for those infants, even if this necessitated obtaining court orders.

The proposed rule was opposed by the AAMC and, among others, the American Academy of Pediatrics, the American Hospital Association, and the American Medical Association. The AAMC expressed dissatisfaction with the regulations on the grounds that they were essentially identical to the invalidated March rule, insinuated that health care providers callously allow children to die from lack of treatment or malnutrition, and provided no guarantees against false accusations and disruption of hospital activities during investigations, or even that HHS would be notified in the event of a decision to withhold treatment or nutrition from a child. The AAMC urged HHS to adopt an alternative approach, under which voluntary institutional Infant Bioethical Review Committees would provide advice and make recommendations in difficult cases.

The final "Baby Doe" regulation, effective in January 1984 and called a compromise by HHS, took account of objections raised by the Association and others to only a minor extent. In the meantime, the parents of another infant, "Baby Jane Doe," who was born with spina bifida, hydrocephaly and microcephaly, had decided against surgery, after carefully considering the pros and cons of repair of the congenital lesions. Almost as soon as the facts became public, HHS instituted suit to obtain the infant's medical records, on the grounds that only through a review of these could it determine whether discrimination on the basis of handicap had occurred. A lower court denial of government access to the records was affirmed by the U.S. Circuit Court; the latter concluded that the Rehabilitation Act was not intended to apply to medical treatment decisions and was, therefore, not a legal basis on which to obtain access to the medical records of "Baby Jane Doe." While the court did not explicitly strike

down the regulations, it seriously undermined the basis on which they were issued. Thereupon, the AAMC joined five other medical associations in a federal suit that asked for an injunction against these regulations, arguing that, if the Rehabilitation Act was not intended to apply to medical treatment decisions, it did not constitute a basis for the HHS regulations. In May, the Federal District Court ruled the final HHS regulations invalid.

While executive branch regulatory intervention was in progress, the Congress pursued a different approach. Both House and Senate bills were introduced that would require hospitals, physicians, and state child protection agencies to insure that medically indicated treatment was administered to all severely ill infants. In essence, the bills would, by amendment, codify the HHS regulations in The Child Abuse, Treatment and Prevention Act. The House bill passed in February. Efforts to incorporate into the Senate version language that would be acceptable to the very broad spectrum of organizations deeply concerned with this issue resulted in an agreement under which instances of withholding of medically indicated treatment would be reported to state child protection agencies which are empowered to take any necessary legal steps to insure that such medically indicated treatment was administered.

Most medical organizations reluctantly agreed to this language. The AAMC and the AMA refused because it still carried an implicit presumption that physicians did not act in the best interest of such babies and because it would force physicians to embark on inhumane and unconscionable management regimes or face the sanctions of this law. The agreement was formally introduced as a bipartisan compromise and passed the Senate unanimously in late July; acceptance by the House is expected.

For the last several years, the efforts of the pharmaceutical industry and others to extend the term of patents by the duration of the delay in marketing due to FDA approval requirements, has been stalemated. Major opposition to patent term extension was based on the conviction that less expensive generic drugs should be made available sooner. A protracted negotiation finally led to the introduction of compromise legislation. The bills proposed to shorten the FDA review process by extending the procedure now used to approve generic copies of pre-1962 drugs to post-1962 drugs. They also extended the patent term for certain entities subject to FDA approval. In instances of extendable patents, the term could be increased by a period of time equal to half of that required for safety and effectiveness testing and for FDA marketing approval; in no case, however,

could the extension exceed five years or the effective patent life, fourteen years. The AAMC is interested in providing adequate patent protection for the discoveries made by medical school faculties and the need for incentives to continue to invest in innovative pharmaceutical research.

Another issue that has emerged on the national agenda is organ transplantation policy. As survival of transplanted organs and the life expectancy of transplant patients has improved, a drastic imbalance has developed between the demand for and the availability of potential donor organs as well as resources to fund the costly medical and surgical procedures involved in organ transplantation. Both Houses have passed legislation to improve a national information system on organ transplantation. A conference on the differences in the two bills is expected.

The Association continued its involvement with problems about disposal of nuclear and hazardous waste materials. Under proposals pending before legislative committees in both chambers, four separate groups of states that have ratified compacts would be authorized to manage their own low-level radioactive waste disposal sites and to exclude other states from access to these sites. Since only three shallow land burial sites, but a least seven "compact groups," currently exist, vital biomedical research and health care activities could be interrupted if the current January 1, 1986 deadline is not extended. The logjam on the state level accounts for the unwillingness or inability of the compact authorizing committees to report out the four compacts submitted. But pressure to act is being brought to bear on the Congress by the three states now saddled with all of the nation's low-level radioactive waste. The AAMC has urged its constituency to encourage action in those states which have not ratified compact agreements, and to promote interregional agreements that would give compact groups lacking a licensed site continued access to existing ones until their own are developed.

On the hazardous waste front, both the House and Senate passed major reauthorizations of the Solid Waste Disposal Act. Both S. 757 and H.R. 2867 require the Environmental Protection Agency to regulate generators of more than 100 kilograms a month of hazardous waste, a stipulation that would bring all academic health centers under EPA's regulatory purview. Regulation of the storage, treatment and disposal of waste would also be significantly tightened. An important issue to be resolved in conference is the threatened prohibition on use of labpacs for the disposal of hazardous waste produced by biomedical research; the placing of liquid hazardous waste in landfills has drawn increasing congressional concern.

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 important health organizations. Among the topics considered during the past year were the need for transitional year residency programs, the relationship of the autonomy of specialty certifying boards to resources for graduate medical education, licensure by endorsement of the certificate of the National Board of Medical Examiners, various aspects of the Medicare prospective payment system, falsification of medical credentials, and the “Baby Doe” regulations of the Department of Health and Human Services.

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 boards of the 50 states and U.S. territories, the Canadian provinces, the Council of 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 been engaged in the preparation of revised accreditation standards for the evaluation of M.D. programs. The draft of revised standards was reviewed by the medical school

deans. The revised document is now being reviewed by the academic and practicing communities prior to its final adoption.

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. This consultation service is also made available to fully developed medical schools desiring assistance in the evaluation of their academic programs.

In 1984 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 proprietary 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. The exposure of a scheme to provide for a price false diplomas and credentials from two schools in the Dominican Republic has brought increased review by licensure bodies of all foreign medical graduates and brought the indictment and conviction of one individual and increasing suspicion of proprietary schools. It is anticipated that within the next several 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 medical schools of unknown quality will have increasing difficulty in securing the residency training required by many states for medical licensure.

In 1984 the Accreditation Council for Continuing Medical Education began implementing the new standards set forth by its revised Essentials.

The Council also approved reciprocity between the ACCME and the Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools as sponsors of continuing medical education. The ACCME adopted "Guidelines for Support of Continuing Medical Education." With the increasing co-sponsorship of CME activities by private industry and schools of medicine, the maintenance of appropriate standards for these activities is facilitated by adherence to the principles expressed in the guidelines.

The Accreditation Council for Graduate Medical Education, after a review of its operating procedures, determined that its responsibilities can be accomplished with three rather than four yearly meetings. This reflects a considerable change; only five years ago six meetings were needed. To a degree, this is due to the delegation of accreditation authority to residency review committees so that the ACGME no longer reviews each of their actions. Periodically the operational record of each RRC is scrutinized by an ACGME subcommittee and deficiencies identified are corrected.

A Task Force on the Evaluation of the Clinical Skills of residency candidates who are graduates of schools not accredited by the Liaison Committee on Medical Education recommended that an assessment of clinical skills by direct observation be incorporated into the certification examinations of the Educational Commission for Foreign Medical Graduates. The ECFMG is developing an assessment protocol for this purpose.

Special requirements for accreditation of transitional year programs were approved by the ACGME and ratified by its five sponsoring organizations. These requirements will be used as the standard for evaluating these one year programs which provide a broad clinical experience in several disciplines.

An announcement by the American Board of Pathology that future candidates for certification must have an additional year of broad clinical training precipitated an intense debate on the prerogatives of certifying boards to alter their certification requirements without consultation with or approval by either the institutions that provide the resources for training or by other specialties whose programs may be affected. The Association, a founding member of the American Board of Medical Specialties, has proposed that the ABMS bylaws be amended to require member boards to submit for ABMS approval any changes in certification requirements that lengthen or otherwise affect graduate medical education resource allocations. The ACGME, at the Association's request, has promulgated a policy that changes in training requirements for any specialty must be widely discussed before adoption by an RRC or approval

by the ACGME may not be forthcoming.

The Educational Commission for Foreign Medical Graduates has now instituted the Foreign Medical Graduate Examination in the Medical Sciences, which replaces both the original ECFMG examination and the VISA Qualifying Examination. In response to recent exposures of fraudulent degrees from some foreign medical schools and because of a widespread breach of security in an administration of the ECFMG exam, more emphasis is being placed on improving the certification process. ECFMG plans to work with original source documents and develop better communications with foreign medical schools to increase its ability to identify forged documents. A committee is developing a method to assess the medical skills of foreign medical graduates. However, the proposed assessment would not evaluate the ability of the graduate to perform a complete history and physical exam, and thus does not entirely meet the Association's concerns that the clinical skills of foreign trained physicians be assessed before they enter training positions in the United States.

As in the two previous years, the Association has played a prominent role in working with other organizations to fashion recommendations for increased appropriations for medical research. More than 150 professional societies and voluntary health organizations comprised the Ad Hoc Group for Medical Research Funding and made a single recommendation to Congress for ADAMHA and NIH. Although the appropriation process is not completed, it appears that Congress will approve an amount for NIH reasonably close to the Ad Hoc Group's recommendation.

Because of the increasing threat at all levels of government to the continued availability of laboratory animals for research, education and testing, the Association, with the American Medical Association and the American Physiological Society, is sponsoring an exploration within the scientific community of means to strengthen significantly efforts to oppose restrictive legislation and other measures.

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 the Intersociety Council for Biology and Medicine.

The Association's Executive Committee meets periodically with its counterpart in the Association of Academic Health Centers. The staffs of the two organizations exchange information and collaborate on programs and have agreed to co-sponsor a study of university ownership of hospitals.

Education

During 1984 the Panel on the General Professional Education of the Physician and College Preparation for Medicine (GPEP) concluded its three-year effort funded by The Henry J. Kaiser Family Foundation. The Panel issued two reports. *Physicians for the Twenty-First Century*, widely disseminated in mid-September, contained five conclusions made by the Panel:

"The general professional education of the physician begins in college, continues through medical school, and extends into the early period of residency. Its purposes are to enable students to acquire the knowledge, skills, values, and attitudes that all physicians should have; and to develop the abilities all physicians need to undertake limited responsibility for patient care under supervision during the early period of their residency..."

"A broad and thorough baccalaureate education is an essential component of the general professional education of physicians..."

"To keep abreast of new scientific information and new technology, physicians continually need to acquire new knowledge and learn new skills. Therefore, a general professional education should prepare medical students to learn throughout their professional lives rather than simply to master current information and techniques..."

"Emerging physicians will best be served by clinical education designed as an integral part of general professional education... Clinical clerkships require careful structuring..."

The last conclusion surrounds enhancing faculty involvement noting, "Despite frequent assertions that the general professional education of medical students is the basic mission of medical schools, it often occupies last place in the competition for faculty time and attention..."

Other important issues discussed in the report include equity of access to a medical career, resources needed for general professional education, accreditation of medical schools, licensure of physicians, graduate medical education, new topics and disciplines, long-term research and educational program evaluation, and continuing medical education.

The Panel's expanded report will appear as a supplement to the *Journal of Medical Education* for November 1984. The *Journal* supplement will contain reports of the Panel's working groups on essential knowledge, fundamental skills, and personal qualities, values, and attitudes. Also included will be reports of the Working Group on Fundamental Skills' six subgroups. These deal with clinical skills, learning skills, medical information science skills, critical appraisal skills—the application of the scientific method, teamwork skills, and personal management skills. A comprehensive status report on medical education in the United States and Canada and a summary report of the Louis Harris and Associates survey on the status of medical education are also included.

Over 20,000 copies of the *Charges to Working Groups* booklet, used nationally by the working groups who examined issues identified by the Panel and intrainstitutionally by the 83 medical schools, 24 colleges and universities, 21 professional societies, and others participating in the project activities, were distributed.

Some efforts already underway might be considered responses to the recommendations implicit in the project. The AAMC curriculum network project was partly the outgrowth of an *ad hoc* meeting of curriculum management personnel at the 1983 AAMC annual meeting. Responses to a mailing of curriculum-related topics were received from over four hundred members of the Group on Medical Education who identified their areas of interest and chose six topics for the first set of networks. Should the curriculum network prove effective and feasible, the number of networks will be expanded. The objective of the program is to provide sufficient information about projects at schools to facilitate further contact among curriculum managers.

During the hearing phase of the GPEP project, it became clear that many curriculum changes were not widely known at other institutions. Some systematic approach to identifying, reviewing, and disseminating information about such innovations seemed useful and important. Accordingly, the GME has instituted a Task Force on the Critique

of Curricular Innovations as a first step for evaluating such efforts.

The Conference on Research in Medical Education has introduced an annual meeting session exclusively for new investigators. This effort signals the intention of the RIME organizers that the conference should be a forum for the widest possible audience in the medical education research and evaluation community. Christine McGuire of the University of Illinois Center for Educational Development will critique medical problem solving literature and related topics as the Second Annual RIME Invited Review.

The AAMC Clinical Evaluation Program is increasing the level of faculty communications both about the process of assessing student clinical performance and the system within which those assessments occur and are transmitted. During the past year, self-assessment instruments have been developed to aid medical schools and clinical departments in identifying problems at each step of the evaluation process. The materials were reviewed in July by the Clinical Evaluation Program Advisory Group, chaired by Daniel Federman of Harvard Medical School. Eight medical schools are currently pilot-testing the materials. This strategy reflects a major conclusion of the study that obstacles to improving the evaluation system have been misdiagnoses of the problems. A final version of the self-assessment instruments will be available in 1985, with follow-up workshops.

Staff is also planning a related effort to assist basic science faculty in their evaluations of student performance. The value and feasibility of such an undertaking, as well as strategies for approaching the project are being studied.

Emphasis continues to be given to generating and disseminating more information about the MCAT and its appropriate use. This has taken the form of intramural research efforts. An annotated bibliography of MCAT research documents 43 studies in print since the new test was introduced. Local validity studies predicting performance in the first two years of medical school have been summarized in a recent report, along with a national study documenting the relationship between MCAT scores and retention and rate of progress of medical students. Staff have turned their attention to studies of special issues in validity, namely, the MCAT's predictive value for women, minorities, and students who take commercial coaching courses. In addition, the AAMC continues to work with schools participating in the MCAT interpretive studies program to identify reliable and valid measures of performance in the clinical years that might serve as further criteria for predictive validity studies.

Continuing and expanding its service to students preparing to take the MCAT and to their college advisors, in 1984 the AAMC published the third edition of the *MCAT Student Manual*. For each of the 108 sample questions, an explanation that describes the content area from which the question was drawn, the reason for the correct answer, and the level of difficulty for each question is included. For the first time, a practice Medical College Admission Test is provided with the *Manual*. This is a complete test identical to the test materials used in an actual test administration. Instructions for taking the test, answer keys, and a method to calculate scores are included.

The development of the Medical College Admission Test experimental essay project has continued under the guidance of an *ad hoc* committee with representation from admissions, minority affairs and undergraduate health professions advisors. The project is being conducted to study the feasibility and desirability of including an essay as a regular component of the MCAT. Data and information gathered over the next two years will serve as a basis for this decision. The first and second round of field tryouts of essay topics were conducted in August and September. The committee and staff hope that essay questions can be included in the 1985 MCAT administration.

In another MCAT matter, the AAMC has cooperated with the Federal Bureau of Investigation and the U.S. Attorney's Office in Philadelphia in a criminal investigation of activities of the Multiprep review course and its owner, Viken Mikaelian. This investigation culminated in May with indictments issued by the federal grand jury charging Mikaelian with several counts of interstate transportation of stolen property and criminal copyright violation. As a result of negotiations with the U.S. Attorney's office, Mikaelian pleaded guilty to two counts of criminal copyright violation and agreed to terminate his MCAT preparation business. In the related civil suit brought against Multiprep, the AAMC filed a motion for contempt of the court's preliminary injunction order, charging Mikaelian with continuing to use copyrighted materials in his course during the summer of 1983.

The Association has been concerned that although many medical schools are using computers and related new technologies for more efficient management and administrative systems, they have yet to realize the potential applications of these tools in other important areas, particularly in the educational process and in clinical decision-making. With the support of the National Library of Medicine, in spring 1985 the Association will sponsor a symposium on medical informatics and medical education.

Biomedical and Behavioral Research

Despite economic constraints, a growing federal budget deficit, and strenuous attempts to limit health care costs, the Congress provided for real growth in the budget of NIH in FY 1984 and will do the same for FY 1985. For FY 1984 NIH appropriations totaled \$4.477 billion, an increase of 11 percent over FY 1983. For 1985 the House and Senate appropriations bills provide for at least 14 percent increase in the NIH budget for authorized programs.

These modest increases since FY 1983 reversed a steady downward trend in the NIH budget in recent years, when appropriations did not keep pace with inflation. Congress has acted to halt this erosion in the nation's biomedical science research capacity in the face of presidential budget proposals to increase the NIH budget by only three percent in FY 1983, one percent in FY 1984 and two percent in FY 1985.

ADAMHA has also been recovering from the blow dealt it in FY 1982 when the president's budget requested a 46 percent decrease and the final appropriation resulted in a 30 percent decrease in the agency's budget for that year. ADAMHA appropriations of \$356 million for FY 1984 were still below those of FY 1981, but it appears that the budget for the coming fiscal year will exceed last year's by at least 14 percent.

Beginning with the 1983 budget process, the Association has spearheaded an effort to unite the research community in advocacy for an appropriate yearly increase in the overall budgets for NIH and ADAMHA. The strategy has involved agreement by the research community on a single overall budget request for NIH and ADAMHA research. Each year the number of organizations participating in this effort has grown and in 1984 over 150 scientific and health-related associations approached Congress with a request for a 14 percent increase in the NIH budget and an 11 percent increase in the research and research training components of ADAMHA. Within this bottom line budget request, the Ad Hoc Group for Medical Research Funding proposed a distribution of the added funds across different types of programs such as individual investigator research awards, clinical trials, research training awards, research

career awards, facilities construction, and Biomedical Research Grants to indicate their intention to strengthen the entire biomedical research effort. Advocacy for disease or institute specific programs has been avoided, although each segment of the community may discuss specific initiatives it supports within the over-all appropriations request. The response of the Appropriations Committees to this unified approach has been very favorable and has contributed to their willingness to increase biomedical research appropriations in a time of fiscal austerity.

The Ad Hoc Group members argued specifically for full funding of the direct costs of research grants at study-section recommended levels and an increase in the number of approved grants which could be funded to a minimum priority score of 185 or at least 37 percent of approved applications. They also requested that funds be provided to meet the National Academy of Sciences recommended number of research trainees and to expand the research career/scientist award programs.

Authorization for key NIH programs has been lacking during FY 1984 because the reauthorization bill was not passed last year and has not yet been passed this year, due in large part to serious objections by various constituencies to a number of provisions in both the House and Senate bills. There is no opposition to the central authorizations for which a renewal bill was necessary; other provisions added to this bill form the basis for the debate it has engendered. These range from provisions to codify the present structure of NIH in statute to mandates for new institutes, provisions for numerous disease specific programs, provisions to restrict fetal research, and language to restrict the use of animals in research.

The successful response to the community-wide effort to secure more research funding coupled with the present research authorization problems led the Association to formulate a position on "Preserving America's Preeminence in Medical Research: Principles for the Support of Biomedical Research." This policy statement articulates the strategy of a united scientific and health research community seeking appropriate overall research funding and broad-based authority for federal

research efforts rather than sharply focused but fragmented efforts to authorize or fund specific projects. Such a strategy would seek to assure maximum flexibility in authorization and maximum flexibility in appropriation requests to permit scientific judgment to be exercised in directing the national research effort. In the last year this policy document has been endorsed by numerous societies, advisory bodies and interested members of the biomedical and behavioral research community.

A number of bills have been introduced in Congress to restrict and/or require greater accountability for the use of animals in research. A powerful and growing public lobby is opposed to research involving animals, and articles, pamphlets and media presentations alleging abuse are becoming more common. Recently a medical school research laboratory was raided by animal rights activists who destroyed research equipment and stole records, representing their actions as justifiable civil disobedience.

The response of the scientific community to these growing threats to research activity has been varied and uncoordinated. The Association is exploring forming an alliance of groups concerned to preserve the portion of the biomedical research effort which must rely on experimentation to advance knowledge. Coordination of resources and efforts might enhance the effectiveness of the scientific community in convincing the public of

the important role of animal research in advancing medical science.

Concern has been mounting about the impact of the restriction of research funds in recent years on the physical condition of aging building and equipment in the research universities. Several studies are underway to examine the present age and condition of research equipment and buildings. An equipment study by the National Science Foundation will survey 34 major research universities and, through the efforts of the AAMC, a partially linked sample of 24 medical schools. An interagency study of all research facilities and construction at a selected group of research universities is planned for the coming year. Efforts are underway to examine the feasibility of reinstating the extramural construction authority of NIH which permitted competitive matching grants to fund research facility construction prior to 1968. The flexibility afforded by recent changes in OMB A-21 accounting regulations to permit including depreciation or user charges for space and interest charges on money borrowed for major capital improvements in the indirect cost pool is also being analyzed as a vehicle for funding capital improvements. There is general agreement that whatever the vehicles made available, a significant federal investment in capital costs for research will be necessary to refurbish the infrastructure and that these funds should be incremental to those now expended on research projects.

Faculty

The Association has a long-standing concern for medical school faculty issues relating to scholarship, research, and research training. These issues include the apparent decline in physicians entering research careers, the difficulty of Ph.D. biomedical scientists in securing appropriate academic appointments, and limitation on research training. Data are collected and analyzed to illuminate these areas, and the results are used to inform discussions by the Administrative Boards and committees. The study results are also used in discussions with staff of the National Institutes of Health and other federal agencies, as well as in preparation of Association testimony for congressional committees.

The Faculty Roster System, initiated in 1966, continues to be a valuable data base with 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.

Following a pilot study in early 1983, a full survey of all full-time faculty in departments of medicine was conducted in cooperation with the Association of Professors of Medicine. Preliminary results of this study were presented to the membership of the APM and to the Manpower Evaluation Advisory Committee of the National Institutes of Health, and a full report is being prepared for publication. The combined data from this survey and the Faculty Roster are a rich source of information on the extent of research activity for over 7,000 faculty members.

During 1984 the Faculty Roster data base was matched to NIH records on research training and

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 which assists medical schools and federal agencies in affirmative action recruitment efforts. Since 1980 approximately 915 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 who have consented to the release of information for this purpose.

As of June 1984, the Faculty Roster contained information on 54,020 full-time salaried faculty and 2,574 part-time faculty. The system also contains 54,496 records for persons who previously held a faculty appointment.

The Association's 1983-84 *Report on Medical School Faculty Salaries* provided compensation data for 122 U.S. medical schools and 34,187 filled full-time faculty positions. The tables present compensation averages and percentile statistics by department and rank for basic and clinical science faculty. Salary data are also displayed according to school ownership, degree held, and geographic region.

An analysis of eleven years of faculty salary data showed that faculty salaries have failed to keep pace with inflation. Real purchasing power declined over the ten-year period by fourteen percent for faculty members in basic science departments and by three percent for faculty members in clinical departments. The results of the study will be published in the *Journal of Medical Education*.

Students

As of August 30, 1984, 35,922 applicants had filed approximately 330,249 applications for the entering class of 1984 in the 127 U.S. medical schools. These totals, although not final, represent an increase in the national applicant pool compared to the final figures for the 1983 entering class. The 1984 applicant pool is estimated to be approximately 36,300 applicants which would represent a three percent increase over 1983-84.

The total number of new entrants to the first year medical school class decreased from 16,567 in 1982 to 16,480 in 1983. Total medical school enrollment rose from 66,748 to 67,327, the highest total enrollment ever.

The number of women new entrants reached 5,370, 3.1 percent higher than 1982; the total number of women enrolled was 20,635, a 5.3 percent increase. Women held 31 percent of the places in the nation's medical schools in 1983 compared to 25 percent five years earlier.

There were 1,399 underrepresented minority new entrants, 8.5 percent of the 1983 first year new entrants. The total number of underrepresented minorities was 5,600 or 8.3 percent of all medical students enrolled in 1983.

The application process was facilitated by the Early Decision Program. For the 1984-85 first-year class, 1,017 applicants were accepted by 67 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 approximately 8,238 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.

One hundred medical schools participated in the American Medical College Application Service (AMCAS) to process first-year application materials for their 1984 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 AMCAS program is guided in the development of its procedures and

policies by the Group on Student Affairs Steering Committee.

The AAMC Advisor Information Service circulates rosters and summaries of applicant and acceptance data to subscribing health professions advisors at undergraduate colleges and universities. In 1983, 291 advisors subscribed to this service.

During each application year, 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 characteristics of the groups of individuals sitting for the Medical College Admission Test remained relatively consistent with the trends observed in previous years. Since 1979, women have increased their representation in the examinee group so that presently 38 percent of all examinees are women, a six percent increase over the past five years. Similarly, the proportion of examinees from groups underrepresented in medicine has enlarged from 19 percent to 23 percent during the same time. The preferred undergraduate major area of study for examinees continues to be in the biological and physical sciences.

The Medical Sciences Knowledge Profile examination was administered for the fifth time in June 1984 to 2,068 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC in evaluating individuals for advanced placement. While six percent of those registering for the test had degrees in other health professions, 88 percent of all registrants were enrolled in a foreign medical school.

Beginning in 1983 a joint effort was initiated to link data from the National Resident Matching Program to the enrolled student file of the AAMC. Listings were then forwarded to the medical schools for corrections and updates on all seniors and their residency assignments. This effort represents another step in the development of a

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research resource for longitudinal studies in medical education and medical manpower.

Monitoring the availability of financial assistance and working to insure adequate funding of the federal financial aid programs used by medical students was a major activity of the AAMC during the past twelve months. As federal financial aid programs shrink and medical school costs rise, concern about the availability and adequacy of financial aid and increasing levels of student indebtedness grows. This concern prompted a study of medical student financing carried out with the support of the Department of Health and Human Services. The Association also worked closely with the schools and DHHS to monitor and reduce delinquency rates in the Health Professions Student Loan program. Comments have been offered to the Department about proposed modifications to the Health Education Assistance Loan program stimulated by concern about potential default rates in that program. The Association joined other professional associations to request that the Secretary of Education exercise his authority to raise the annual and aggregate borrowing limits for Guaranteed Student Loans. Current authorization for all federal programs of student assistance contained in the Higher Education Act and the Health Professions Education Assistance Act expires in FY 1985. Because the aid programs are vital to medical students, the AAMC has put a great deal of effort into activities directed to reauthorization of these programs. In addition, the issues of loan consolidation for student borrowers and issuance of tax exempt bonds to fund student aid programs have been addressed. The AAMC also produced a financial planning and management manual for medical students, residents, pre-medical students and their families.

Through its Office of Minority Affairs, the AAMC is administering several projects to enhance opportunities for minorities in medical education. Several Health Career Opportunity Program grants were received. The first grant provided three types of workshops to reinforce and develop effective programs for the recruitment and retention of students underrepresented in medicine. Of these, the Simulated Minority Admissions Exercise Workshop is for medical school personnel concerned with the admission and retention of minority students. The Student Financing Workshop teaches expertise in financial counseling and administering aid to minority students. The Training and Development Workshops for

Counselors and Advisors of Minority Students provide information about ethnic and racial minority students and train counselors and advisors to work with the latest techniques appropriate for underrepresented minority students. An important objective is to have participants gain information about the differences among minority groups and to help participants develop alternative techniques for each group.

A second grant to evaluate retention activities in medical schools measured the effect of Health Career Opportunity Program-funded retention programs on attrition of minority medical students. With Robert Wood Johnson Foundation support the Office of Minority Affairs developed *Minority Students in Medical Education: Facts and Figures*. Other work has been carried out with the Macy Foundation to determine the extent of minority medical student participation in special enrichment or preparatory programs.

The *1984-85 Minority Student Opportunities in U.S. Medical Schools* was distributed to U.S. medical schools, health professions advisors, and libraries. This biennial publication describes minority student programs and recruitment activities of each medical school.

The Group on Student Affairs-Minority Affairs Section held a Medical Career Awareness Workshop for minority students which was attended by 250 high school and college students. Fifty-seven medical schools were represented.

The 1984 medical student graduation questionnaire was administered in all U.S. medical schools with seniors, with 10,547 students participating in the survey. This represents a 64 percent response rate. The majority of the 1984 respondents planned to be in a residency their first year after graduation, with the most frequently selected specialties family practice and internal medicine. Of 1984 graduates, 24 percent designated a research-related career as their first choice, compared to 25 percent in 1983 and 22 percent in 1982. The average medical school debt of indebted respondents was \$24,328, representing a 12 percent increase from last year. Almost 32 percent of the respondents reported total educational debts of \$30,000 or more, compared to under 25 percent in 1983. A summary report comparing each school's response to national data was provided to each school in September. Selected results appear in the 1984 directory of the National Resident Matching Program.

Institutional Development

The Association enhances the leadership and management capabilities of its member institutions by sponsoring management education programs. Now in its thirteenth year, this series of programs has traditionally emphasized executive development seminars for senior academic medical center officials—intensive, week-long seminars on management theory and techniques. During the last year, two such seminars were offered to medical school department chairmen, assistant and associate deans, and hospital executives. Seventy-eight individuals from 59 institutions participated. The seminars assist institutions in integrating organizational and individual objectives, strengthening the decision-making and problem-solving capabilities of academic medical center administrators, developing strategies for more flexible adaptation to changing environments, and developing a better understanding of the function and structure of the academic medical center.

Executive Council guidance that new emphasis be placed on continuing management education needs of AAMC members resulted in several short, intensive workshops focusing on human resources management, financial management, marketing, and information resources management. These workshops combine an emphasis on fundamental concepts with illustrations and exercises to highlight their applicability to current medical center issues and problems. Three of these workshops were offered in 1984. The first, "Managing the Professional: Challenges for the Academic Medical Center," addressed the need for creative, effective strategies for managing the institution's human resources more effectively.

The second in the series, "Financial Management," was designed for those with financial management responsibilities and explored environmental changes affecting the missions of

the academic medical center and their financial ramifications. It provided an intensive introduction to basic financial management concepts and approaches fundamental to an analysis of the challenge presented.

The third seminar, "Strategic Marketing: Managing in a Competitive Environment," developed an approach to marketing as both a philosophy and a management tool. As a philosophy, marketing energizes an institution to formulate its programs so that they meet needs in an effective and attractive manner. As a management tool, marketing provides an approach to the analysis of institutional performance that complements other, more traditional approaches.

The final seminar in the new series, "Information Management in the Academic Medical Center," scheduled for January 1985, will explore the problems and opportunities created by the revolutionary changes in the technology of information management.

For the fourth year a seminar focusing on the academic medical center/VA medical center affiliation relationship was conducted for VA medical center executives as part of their professional development program. This program was sponsored with the Veterans Administration Central Office.

An advanced executive development seminar for deans who have participated in the basic program is now being planned. This program capitalizes on more recent work of the program faculty and will address the process of technological innovation, planning for the acquisition and management of high technology resources for research and patient care, changes in demographics and economics in clinical practice and their implications for medical center patient care enterprises, and managing interdisciplinary efforts.

Teaching Hospitals

Amendments to the Social Security Act signed into law in March 1983 prescribed a new Medicare prospective payment system based on Diagnosis Related Groups (DRGs). While awaiting publication of the regulations implementing the system, the AAMC learned of an effort by the Office of Management and Budget to have the Health Care Financing Administration reduce the DRG prices to offset what OMB feared would be a marked increase in Medicare admissions in response to the new incentives. AAMC and AHA wrote OMB Director David Stockman protesting this proposed reduction. The letter pointed out that the Social Security Act did not provide for such a reduction, but did authorize Peer Review Organizations to monitor admissions and disallow inappropriate utilization. The peer review program would assure that any increase in admissions reflected an increased incidence of illness and the growing number of elderly.

Interim final regulations implementing the Medicare prospective payment system were published on September 1, 1983 and outlined the methodology by which payments are made to hospitals for Medicare patients. Weights have been established for each DRG based on a computed average cost per admission. These weights are then applied against a blend of regional, national, and hospital-specific average costs per case. At the end of three years, this blend disappears and the payments will be based on national averages. Currently capital and direct medical education costs are excluded from prospective payment and are paid on a cost basis. The AAMC considered the implications of the regulations for teaching hospitals and supported per diem payments to hospitals transferring patients, coverage of the costs of kidney acquisition, elimination of restricted fund offset against an institution's allowable costs, and the modification of the application of reasonable compensation equivalents to apply to physician compensation for service paid on a retrospective basis.

The Association also objected to several provisions in the regulations. Of particular concern was the method for computing the number of residents in each hospital's resident-to-bed ratio. The

method used the sum of interns and residents employed by the hospital 35 hours or more per week plus half the number of interns and residents working less than 35 hours per week. The AAMC objected because of the requirement that the hospital have an employment relationship with the resident, and the presumption of a full-time 35 hour work week, which is substantially shorter than the number of hours most residents spend in the hospital. Also criticized were the absence of adjustments for referral centers and hospitals with a disproportionate number of low income and Medicare patients, the insufficiency of outlier payments, calculation of the wage indices for urban and rural payment levels, the treatment of payment to hospitals during the transition period from cost to prospective payments, and the exclusion of the medical library as an educational cost. The letter concluded by emphasizing the need for the Department of Health and Human Services to address the provision of care to indigent and underfinanced patients.

A consistent problem for AAMC constituents has been a misunderstanding of the indirect medical education adjustment as a means of representing some of the factors that legitimately increase costs in teaching hospitals. The Association has commissioned a paper from Judith R. Lave, professor of health economics at the University of Pittsburgh, on the description of the history, development and future prospects for this "indirect medical education" payment. This paper will be available in fall 1984.

Final prospective payment regulations published in January 1984 included several significant changes in response to comments received from the hospitals. AAMC concerns were met, in part, by a moderate change permitting hospitals to count residents and interns employed by other organizations with which they have a "longstanding historical relationship." In the preamble to the final rule, HCFA acknowledged that there were ways other than employed time which would accurately count residents, but felt the need to review the data to select the best option. According to HCFA's interpretation of this language, a hospital can count both its own "employed"

residents and residents trained in the hospital but paid by another organization as long as no resident is counted more than once.

In clarifying allowable costs under the prospective payment system, HCFA explicitly excluded three items of particular interest to AAMC members: the medical education expenses for the clinical training of "students not enrolled in an approved education program operated by the provider," the cost of care for patients admitted solely or primarily for noncovered services, and payments under the cost outlier provision for patients who are also outliers for length of stay.

A Prospective Payment Assessment Commission was established under the Office of Technology Assessment to advise Congress and HHS regarding this payment system. The Commission was charged with determining how to incorporate new technology and new treatment modalities into the pricing system, helping to determine the annual increase factor, and defining appropriate medical practice patterns for specific diagnoses. To assure appropriate funding for this Commission, the AAMC supported its budget request and pointed out that it is imperative that a body such as the Commission monitor changes in the health delivery system brought about by the switch to prospective payments to ensure that the quality of care for Medicare beneficiaries is not adversely affected or the fiscal stability of hospitals unintentionally jeopardized. The subcommittee members were reminded that, "absent this Commission, the Department of Health and Human Services would be payor, regulator and evaluator" simultaneously. The AAMC supported the objective viewpoint this Commission would provide.

In keeping with AAMC concerns about reimbursement issues and future mechanisms for incorporating capital costs into the payment scheme, an ad hoc Committee on Capital Payments for Hospitals Under Medicare was appointed in early 1984. The committee met twice and reviewed a paper entitled "Toward an Understanding of Capital Costs in COTH Hospitals." This paper described capital costs and operating expenses in COTH and non-COTH hospitals. The Committee reviewed options and possible methodologies for incorporating capital costs into the DRG system and recommended a prospectively determined and specified capital payment. The committee suggested separating major movable equipment from fixed equipment and plant. The costs of the major movable equipment ought to be incorporated in the DRG payments immediately, the Committee believed, but the fixed equipment and plant costs ought to be incorporated over the course of a several year transition period. However, because it

was unable to reach a conclusion concerning an appropriate transition mechanism to move from cost-based to prospective payments for capital costs, the Committee requested guidance from the AAMC Executive Council.

The AAMC wrote the Ways and Means Committee supporting a proposal that would slow the transition to national DRG rates by retaining for an additional year the current formula in which 75 percent of the payment each hospital receives is based on its own costs and 25 percent is based on the regional DRG rates. Otherwise, Medicare payments to hospitals for the fiscal year beginning on or after October 1, 1984 would be based half on the hospital's own costs, 37.5 percent on the regional DRG rates and 12.5 percent on the national DRG rates as in the legislation that established the system. The bill was not passed.

In the spring and summer of 1984, the AAMC was increasingly concerned about additional substantial cuts in Medicare/Medicaid in fiscal year 1985. The Tax Reform Act of 1984 mandated many changes that directly affect physicians and hospitals, including a freeze on Medicare fees for physician services, the establishment of new floors for Medicare fees in a teaching setting, limitations on payment for laboratory services provided to outpatients, increases in price per case limited to market basket plus one-quarter of one percent, a study of area wage indices, clarification in the method of counting residents in training within the institution, payment for nurse anesthetist services on a cost-based pass through, an expanded definition of referral centers change in the classification criteria for urban hospitals, and an exemption for some hospitals from the cost-to-charge test for outpatient services.

No hearings were held on any of these matters. The AAMC objected particularly to the elimination of the one percent new technology factor from the Medicare prospective payment system, replacing the required market-basket adjustment for hospital payments with a fixed and arbitrary inflation percentage, and arbitrary cuts in the federal matching share for Medicaid programs. The Association noted that the recent changes in hospital payments under the Medicare and Medicaid programs required substantial operational changes in hospitals.

In 1983 the presidentially appointed Advisory Council on Social Security began to consider Medicare payments for the costs of medical and other health professional education. Declaring that it was inappropriate for Medicare to pay for anything except patient care, the Council called for a study on restructuring medical education financing to provide for an orderly withdrawal of Medicare funds from training support. AAMC

TEACHING HOSPITALS

testified against this resolution, cautioning that even an "orderly withdrawal" would be premature until the Council determined what Medicare pays for under the label for direct medical education. A clearly described, administratively feasible, and politically acceptable funding alternative must be found to support the joint products of educational experience and clinical care services.

The Advisory Council on Social Security altered its original recommendation to state that the costs of training medical personnel should be provided by a variety of sources, rather than by the Medicare program, and that HHS should "identify and develop other federal, state, and local funding sources." The recommendation also stated, "The Council thinks that the involvement of the Medicare program in underwriting these costs is inappropriate since the program is designed to pay for medical services for the elderly, rather than to underwrite the costs of training and medical education."

In a similar vein, a report drafted by the HHS Office of the Inspector General recommended changes in Medicare's payments to hospitals for residents' services. The AAMC voiced serious concerns about this report and met with HHS officials and Secretary Margaret Heckler to discuss it. Based on an assumption that the amount Medicare pays for these services is too high, the report proposes two changes. Teaching hospitals could claim the cost of residents' patient care services for only the first year of residency. Further, reimbursement on a reasonable charge basis for physician services would be permitted whether provided by a teaching physician or a resident who has completed the first postgraduate year of training and met the state licensure requirements. The total charge for the combined services of the resident and teaching physician should not exceed the reasonable charge allowable for the same service in a non-teaching situation.

On August 15 the *Federal Register* contained proposed regulations governing utilization and quality control criteria for Peer Review Organizations, PRO area designations, and definitions of eligible organizations. The regulations stated that HCFA will determine that an organization is capable of conducting utilization and quality review if "the organization's proposed review system is adequate" and its "quantifiable objectives are acceptable." It is not clear from the proposed regulations what criteria will be used. The AAMC stated that such criteria must include explicit consideration of the views of the affected parties and, therefore, an "adequate" review system must contain provision for an appeal and reconsideration mechanism that could accommodate the due process rights of affected parties.

Moreover, where an adverse decision is to be made by a PRO on a review matter, the preliminary findings should be reported to the institution in question to provide an opportunity to submit additional clarifying information prior to the PRO's "final" decision.

The implications of the conditions of eligibility that would determine the performance effectiveness of the PRO on its ability to meet "acceptable quantifiable" objectives also concerned the AAMC. There is no language in the proposed regulations that explains what HCFA desires the PRO to quantify. The AAMC has expressed its objections to requiring that PROs establish a target rate for achieving Medicare program savings above and beyond PRO contracted costs. Efficiency should be encouraged, but suggesting reimbursement cost-cutting as the primary PRO goal belies the intent of the program—monitoring the quality of Medicare care.

Further implementing regulations were proposed by HCFA on "Acquisition, Protection, and Disclosure of Utilization and Quality Control Peer Review Organization (PRO) Information" and "Sanctions on Health Care Providers and Practitioners." Problems existed with both regulations because they lacked qualifying descriptions of terms and because of the absence of any reassurance that hospital confidentiality is considered a right to be protected.

A discussion of the "Implications of For-Profit Enterprise in Health Care" was held by the Institute of Medicine. Robert M. Heyssel represented the AAMC. He stated that the investor-owned corporations have a legal obligation to their shareholders, and that each decision a corporation makes with regard to service mix, program selection, and population served will have an impact on earnings per share. The issue, he said, is whether certain very necessary societal functions can be continued, because patient service revenues in the teaching hospital are the dollar stream that supports societal contributions such as the provision of tertiary care services, educational endeavors, research initiatives, and care of indigent patients.

A revised publication entitled "Medical Education Costs in Teaching Hospitals, An Annotated Bibliography" was published in April 1984 and includes a compendium of abstracts on research on the costs of medical education in teaching hospitals and abstracts of papers addressing the issue of modifying practices to reduce costs. 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.

Communications

Media attention on the Association's General Professional Education of the Physical project remained high during the year and came to a focus in September when the AAMC released the study at two news conferences and a European teleconference. Members of the panel that conducted the study discussed their findings via an Oslo and Soria Moria, Norway teleconference, during a meeting of the Association of Medical Education in Europe. Following the teleconference, news conferences were held in Washington and New York.

The Association works with the national media and responds weekly to a large variety of media queries for interviews, information and Association policy positions. A major topic of media inquiry concerned the Association's legal action against the test preparation company Multiprep and the guilty plea of its founder Viken Mikaelian to two counts of criminal copyright infringement.

The chief publication of the Association is the *AAMC President's Weekly Activities Report*. This report, which is published 43 times a year, circulates to more than 7,000 and covers AAMC activities and federal actions that directly affect the AAMC constituency.

The *Journal of Medical Education* published 1,015 pages of editorial material in the regular monthly issues, compared with 999 pages the previous year. The published material included 89 regular articles, 59 communications, and 17 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 6,150. The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1983-84 totaled a near record of 434, of which 149 were accepted for publication, 207 were rejected, 16 were withdrawn, and 62 were pending as the year ended.

About 24,000 copies of the annual *Medical School Admission Requirements*, 4,000 copies of the *AAMC Directory of American Medical Education*, and 4,000 copies of the *AAMC Curriculum Directory* were published. Numerous other publications, such as directories, reports, papers, studies, and proceedings were also distributed by the AAMC. Newsletters include the *COTH Report*, which has a monthly circulation of 2,250; 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, issued three new books in 1984: *Continuing Education for the Health Professions, New and Expanded Medical Schools, Mid-Century to the 1980s*, and *Leadership and Governance in Academic Medicine*.

Information Systems

The Association continues to upgrade its general purpose computer system to insure that it will meet the ever-increasing needs of the Association membership and staff. A Hewlett-Packard 3000, Series 68 has replaced the Series 64 and a Hewlett-Packard 3000, Series 48 has replaced the Series 44. These changes enabled the Association to improve response time and provide enhanced data communications. During the past year, high volume printing requirements increased and a second high speed laser printer was added to the computer system. The constant demand for detailed information necessitates the use of over 100 terminals to access the Association files. To insure the reliable retrieval of historical data from off-line storage media, the Association added two high density tape drives and made substantial improvements to the tape storage facility. Data bases are developed to minimize data redundancy and to provide responsive, on-line retrieval of information. Computer generated graphic art now provides illustrations in final publication form thereby reducing camera art preparation and outside printing costs.

While the cyclic processing of the individual student's 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 schools to receive the most current update of a particular applicant's file. Rosters, 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 permits 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 and 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 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. The Association, using an initial data file supplied by NRMP, produces match results listings for each medical school, updates the NRMP information using current student records system data and listings returned from the medical schools, prepares hospital assignment lists for each medical school, and generates 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, multiple systems have been consolidated into one Student and Applicant Information Management System. The system currently produces a wide variety of reports describing students, applicants and graduates, answers special data requests for information from constituents, and provides data study files for additional statistical analysis.

Through the cooperation of the medical school staffs, the Association updates the Faculty Roster system's information on salaried faculty at U.S. medical schools and periodically provides schools with an organized, systematic profile of their facul-

ty. The Association's survey of medical school faculty salaries is published annually and is available on a confidential, aggregated basis in response to special queries.

The Association maintains 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 contains items used for on-line retrieval 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 hospitals.

In addition to the major information systems of the Association a number of specialized systems support the activities of the Councils and Groups of the Association. Mailing labels, individualized correspondence, and laser-produced photocomposed directories are examples of the services provided.

A new membership system is being initiated to integrate the services provided by many of the specialized systems now in use. It will continue to produce labels for the *Weekly Activities Report* and the *Journal of Medical Education*.

The rapid assimilation of data into useful information coupled with timely distribution to the Association membership to allow informed decision-making continues to be our goal.

Treasurer's Report

The Association's Audit Committee met on September 4, 1984, and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1984. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 13, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled \$12,328,998. Of that amount, \$11,486,753 (93%) originated from general fund sources; \$229,351 (2%) from foundation grants; \$612,894 (5%) from federal government grants and contracts.

Expenses for the year totaled \$10,226,320 of which \$9,316,938 (91%) was chargeable to the continuing activities of the Association; \$296,488 (3%) to foundation grants; \$612,894 (6%) to federal government grants and contracts. Investment in fixed assets (net of depreciation) increased by

\$420,293 as a result of an upgrade in computer equipment.

Balances in funds restricted by the grantor decreased \$20,450 to \$479,211. After making provisions for reserves in the amount of \$200,000 for MCAT and AMCAS development, unrestricted funds available for general purposes increased \$1,466,791 to \$9,706,641, an amount equal to 95% 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.

TREASURER'S REPORT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES BALANCE SHEET June 30, 1984

ASSETS	
Cash	\$ 181,654
Investments	
Certificates of Deposit	15,701,035
Accounts Receivable	901,329
Deposits and Prepaid Items	169,421
Equipment (Net of Depreciation)	1,334,266
TOTAL ASSETS	<u>18,287,705</u>

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		1,080,818
Deferred Income		1,448,580
Fund Balances		
Funds Restricted by Grantor for Special Purposes		479,211
General Funds		
Funds Restricted for Plant Investment	\$ 496,856	
Funds Restricted by Executive Council for Special Purposes	3,741,333	
Investment in Fixed Assets	1,334,266	
General Purposes Fund	9,706,641	15,279,096
TOTAL LIABILITIES AND FUND BALANCES		<u>\$18,287,705</u>

ASSOCIATION OF AMERICAN MEDICAL COLLEGES OPERATING STATEMENT Fiscal Year Ended June 30, 1984

SOURCE OF FUNDS

Income		
Dues and Service Fees from Members		\$ 3,120,430
Private Grants		229,351
Cost Reimbursement Contracts		612,894
Special Services		5,531,355
Journal of Medical Education		97,965
Other Publications		340,708
Sundry (Interest \$1,594,493)		2,396,295
TOTAL SOURCE OF FUNDS		<u>\$12,328,998</u>

USE OF FUNDS

Operating Expenses		
Salaries and Wages		\$ 4,670,282
Staff Benefits		822,328
Supplies and Services		3,063,656
Provision for Depreciation		313,644
Travel and Meetings		948,668
Subcontracts		406,685
Interest Expense		1,057
TOTAL EXPENSES		<u>\$10,226,320</u>
Increase in Investment in Fixed Assets (Net of Depreciation)		\$ 420,293
Transfer to Executive Council Reserved Funds for Special Programs		200,000
Reserve for Replacement of Equipment		36,044
Increase in Restricted Fund Balances (Decrease)		(20,450)
Increase in General Purposes Funds		1,466,791
TOTAL USE OF FUNDS		<u>\$12,328,998</u>

AAMC Membership

	1982-83	1983-84
Institutional	125	125
Provisional Institutional	2	2
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	18	16
Academic Societies	73	76
Teaching Hospitals	432	434
Corresponding	87	47
Individual	1174	1099
Distinguished Service	62	65
Emeritus	68	60
Contributing	5	5
Sustaining	10	10

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