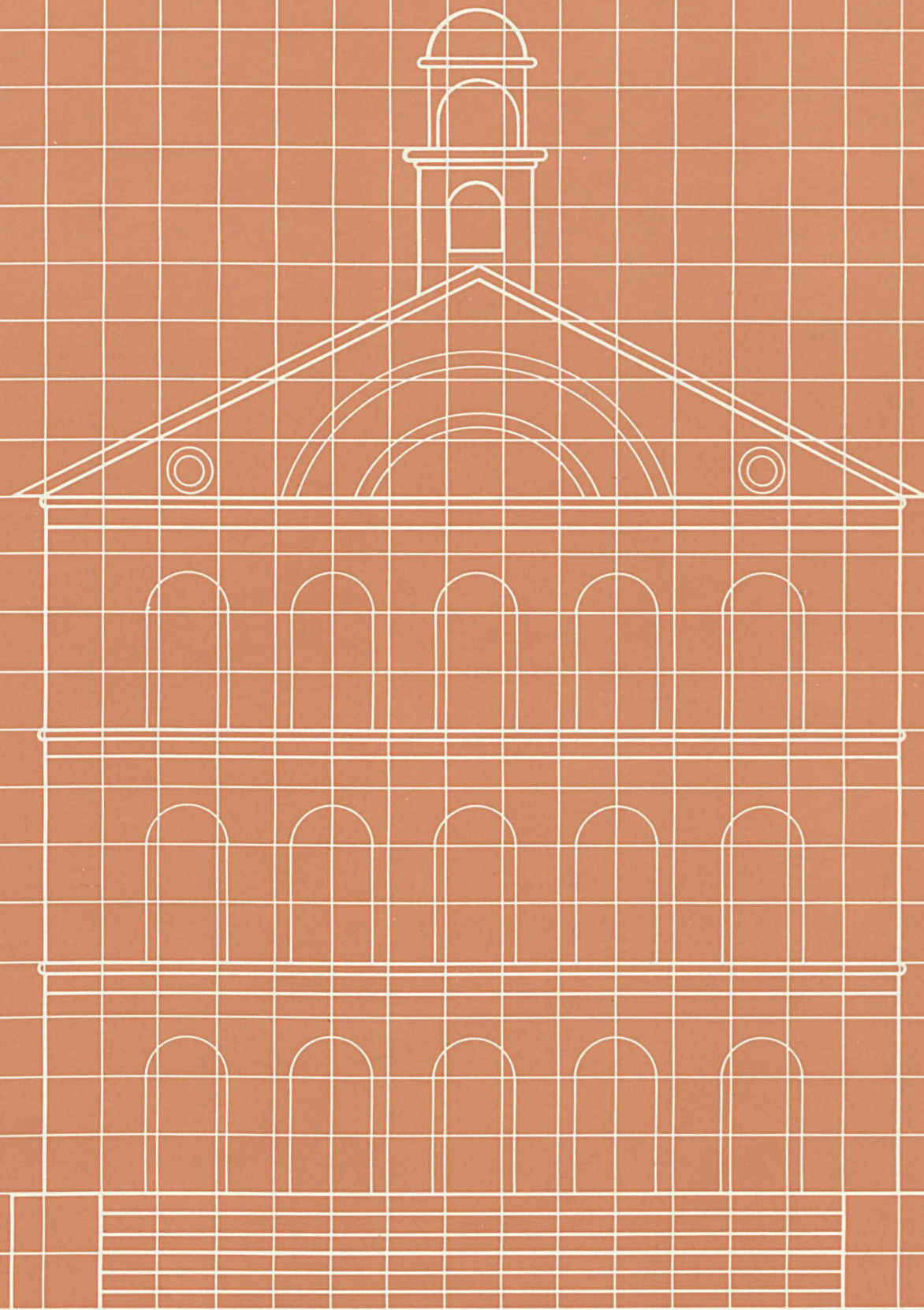


# 1981-82 ANNUAL REPORT



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

# Executive Council

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*Chairman*

Thomas K. Oliver, Jr.

*Chairman-Elect*

Steven C. Beering

*President*

John A. D. Cooper

*Council Representatives:*

**Council of Academic Societies**

David M. Brown  
Daniel X. Freedman  
Virginia V. Weldon  
Frank C. Wilson, Jr.

**Distinguished Service Member**

Manson Meads

**Council of Deans**

Steven C. Beering  
John E. Chapman  
John W. Eckstein  
Richard Janeway  
William H. Luginbuhl  
Richard H. Moy  
Leonard M. Napolitano  
M. Roy Schwarz  
Edward J. Stemmler

**Council of Teaching Hospitals**

Mark S. Levitan  
Stuart J. Marylander  
Mitchell T. Rabkin  
John Reinertsen

**Organization of Student Representatives**

Grady Hughes  
Edward Schwager

# Executive Committee

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*Chairman*

Thomas K. Oliver, Jr.

*Chairman-Elect*

Steven C. Beering

*President*

John A. D. Cooper

*Chairman, Council of Academic Societies*

David M. Brown

*Chairman, Council of Deans*

William H. Luginbuhl

*Chairman, Council of Teaching Hospitals*

Mitchell T. Rabkin

# 1981-82 ANNUAL REPORT

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

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# Executive Summary

The American Association of Medical Colleges (AAMC) is pleased to present its 1981-82 Annual Report. This report provides a comprehensive overview of the Association's activities and achievements during the past year. The report is organized into several sections, each focusing on a different aspect of the Association's work. The Executive Summary provides a high-level overview of the Association's mission and goals, as well as a summary of the key findings and recommendations of the report. The Chairman's Report, President's Report, and Secretary's Report provide detailed accounts of the Association's activities and achievements during the past year. The Financial Report provides a detailed overview of the Association's financial performance, including a summary of the Association's income and expenses, as well as a discussion of the Association's financial position and outlook. The Administrative Report, Academic Report, Medical Education Report, Research Report, and Public Affairs Report provide detailed accounts of the Association's activities and achievements in these areas. The Appendices provide additional information and data related to the Association's activities and achievements during the past year.

## President's Message

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During the past year, the medical schools and their teaching hospitals have been buffeted by gale force winds from the nation's social and economic weather. Although no ship has gone down, and one university has even launched a new medical school into the stormy seas, masts have been snapped, sails tattered, and pumps strain to keep the academic medical centers afloat.

With the diminished interest in social programs, and the requirements of the defense maw, student financial assistance has been severely cut back. In a deteriorating economy, the ability to pay the rising costs of tuition, fees, books and subsistence has become a more important factor in who will apply to medical school and who will enroll. High interest rates for loans, the long and arduous education and training programs for medicine, and the prospect of an oversupply of physicians are turning students to other careers. The number of applicants has fallen sharply from the peak in 1974-75. The decrease would have been even steeper if an increase in women applicants hadn't moderated the reduction in male applicants. The income of applicants' families has risen in constant dollars and more parents are professionals and managers and fewer are from the working class. The success that medical schools have had in broadening the socioeconomic distribution of medical school classes is being reversed.

A smaller percentage of young people are completing college. The nation is not developing and protecting its most valuable resource—individuals educated to the highest level of their abilities. There is an increasing possibility that we may lose our preeminence in the world of science and technology and may yet fulfill Mr. Jefferson's vision of an agrarian America.

Our nation's position will be weakened further by the reduction in federal research support. In constant dollars NIH funding has gone down five percent a year since 1979. Our understanding of living systems and the changes brought about by disease has advanced geometrically during the past decade. These new insights, which have revolutionized medical practice, have been built on the base of fundamental knowledge carefully developed over three decades. At a time when prospects for even greater discoveries in the biomedical sciences have never been better, investigators find it more difficult to support their research. Opportunities to improve and, in the long run, reduce the costs of prevention, diagnosis and therapy of disease are lost. This situation has diminished the interest of bright young physicians in preparing themselves for a career in research and accelerated the dismantling of the greatest research enterprise in history.

The diminished concern with social programs affects the academic medical centers and their teaching hospitals in additional ways. With reductions in other sources of support, the medical schools have turned to the marketplace. The medical services rendered by the faculty have become a major source of income for the institutions. Almost one half of the general operating budgets of medical schools comes from medical services provided by the faculty. Now this income and that of the teaching hospitals are being threatened by already instituted or promised future reductions in payment for medical care, particularly for the poor and the elderly. In order to survive, it may be necessary for medical schools and their teaching hospitals to reduce the amount of care they provide to the needy. If this is accompanied by a decrease in the reimbursement for the complex care provided in the teaching setting, the academic medical enterprise faces serious problems. These activities cannot be placed on hold for the duration of the fiscal crisis facing the country, and once they are lost will require a long time to redevelop.

The country is in deep economic trouble and the approaches being used to reverse the situation have not solved the problems. Changes in the social, economic and political environment are taking their toll on the academic medical centers and their teaching hospitals. We must believe that economic and social conditions will improve; however, there is little reason to believe they will return to the norms of the past.

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

# Administrative Boards of the Councils

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## Council of Academic Societies

### *Chairman*

David M. Brown

### *Chairman-Elect*

Frank C. Wilson, Jr.

Bernadine H. Bulkley  
David H. Cohen  
Daniel X. Freedman  
William F. Ganong  
Lowell M. Greenbaum  
Robert L. Hill  
T. R. Johns, III  
Joseph E. Johnson, III  
Douglas Kelly  
John B. Lynch  
Virginia V. Weldon

## Council of Deans

### *Chairman*

William H. Luginbuhl

### *Chairman-Elect*

Richard Janeway

Steven C. Beering  
Arnold L. Brown  
John E. Chapman  
D. Kay Clawson  
William B. Deal  
John W. Eckstein  
Richard H. Moy  
Leonard M. Napolitano  
M. Roy Schwarz  
Edward J. Stemmler

## Council of Teaching Hospitals

### *Chairman*

Mitchell T. Rabkin

### *Chairman-Elect*

Mark S. Levitan

James W. Bartlett  
Fred J. Cowell  
Jeptha W. Dalston  
Spencer Foreman  
Robert E. Frank  
Earl J. Frederick  
Irwin Goldberg  
Sheldon S. King  
Stuart J. Marylander  
John A. Reinertsen  
Haynes Rice  
John V. Sheehan

## Organization of Student Representatives

### *Chairperson*

Grady Hughes

### *Chairperson-Elect*

Edward Schwager

David Baum  
Lisa Capaldini  
Pamelyn Close  
Beth Fisher  
Linda McKibben  
Paul Organ  
David Thom  
Michael Tom  
Ron Voorhees

# The Councils

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## EXECUTIVE COUNCIL

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

The traditional December retreat for newly elected officers and senior staff of the Association continued discussions initiated at a special joint meeting of all Administrative Boards in September 1981. That session, "Strategies for the Future," had focused on issues facing medical schools and teaching hospitals and their faculties and students in the 1980s. Retreat participants studied these issues and related data and developed a work plan setting forth both short-term and long-term goals and priorities for the Association. The work plan was further reviewed and refined throughout the year in discussions at the Administrative Boards and Executive Council meetings.

As the President's fiscal year 1983 budget was developed, and as the legislative process progressed, the Executive Council reaffirmed as the top priorities for the Association research and research training, student financial assistance, and Medicare and Medicaid. In each of these areas the Council reviewed and acted on many policy issues.

The fiscal year 1983 budget request for the National Institutes of Health had programmatic implications that concerned Association constituents. One component of the request in particular, a proposal to limit indirect cost reimbursement on research awards to 90% of the negotiated rate, was viewed as seriously threatening to the institutional research base in medical centers. The Executive Council opposed such limitations despite the possibility that the alternative would be less money available for research awards. The balance in funding between intramural and extramural research

was also discussed. Although support for the NIH intramural program was reiterated, the Council reminded NIH that the reasons given for the increased funding for the intramural program—higher energy prices, salary increases, and higher equipment and supply costs—also obtained for the extramural program.

The Executive Council reviewed several bills renewing or revising expiring NIH authorities. Of particular concern was the potential fragmentation of the research endeavor by the proliferation of separate institutes.

The Executive Council authorized an effort to determine the feasibility of initiating a nationwide public relations effort to inform the public and policy-makers about the benefits of and need for strong support for biomedical and behavioral research. If undertaken, the effort could culminate in the designation of a National Medical Research Month.

The First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was, in general, favorably received by the Executive Council. An Association response to the report identified specific problems relating to inadequate definition of adverse reactions, research involving institutionalized mentally disabled persons, and reporting requirements.

After discussing federal efforts to develop and evaluate methods of containing Medicare and Medicaid expenditures, the Executive Council directed Association staff to actively pursue explicit recognition of hospital patient mix, including differences in diagnosis, intensity of illness and type of patient, in all hospital payment limitations and prospective payment systems. This position also guided the Executive Council as it reviewed the proposed Medicare prospective payment system developed by the American Hospital Association.

As a parent organization of the Accreditation Council for Graduate Medical Education and the Accreditation Council for Continuing Medical Education, the Association must review and approve

## THE COUNCILS

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policy decisions by these organizations. The Executive Council approved a revision to the ACGME general essentials to allow graduates of schools accredited by the Liaison Committee on Medical Education and the American Osteopathic Association to enter graduate medical education without further examination or other requirements; graduates of other schools are required to pass an ACGME-approved examination of their cognitive skills. For the ACCME, the Executive Council approved the Essentials for the Accreditation of Sponsors of Continuing Medical Education and a statement on eligibility for accreditation.

The Executive Council endorsed the recommendations of an AAMC Report on *Academic Information in the Academic Health Sciences Center*. The Council also approved a change in the medical school admissions "traffic rules" that would extend the period in which schools could offer acceptances without jeopardizing the Early Decision Program.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of committees. An *ad hoc* Committee on Health Planning, chaired by C. Thomas Smith, presented a report that was adopted at the Council's April meeting. The Association position supported streamlined community-based health planning with mandatory state certificate of need programs and an explicit recognition of the unique roles and needs of academic medical centers and teaching hospitals.

The *ad hoc* Committee on the Maintenance of High Ethical Standards in the Conduct of Research, under the chairmanship of Julius R. Krevans, was established in response to Executive Council concerns that the wide attention received by isolated instances of misconduct by biomedical investigators would call into question the integrity of the whole research enterprise. The committee report, as adopted by the full Council, emphasizes the critical importance of maintaining public trust in the research process and also urges faculties to assume primary responsibility for promoting an environment fostering the highest principles of honesty and openness in research. The report also provides prototype guidelines and procedures to assist schools in dealing with allegations of fraud.

During the course of the year the Executive Council also reviewed the activities of the Advisory Panel for the General Professional Education of the Physician project and the Steering Committee of the Regional Institutes in Geriatrics and Medical Education effort.

In September the Executive Council had a special briefing session for the Administrative Boards of the Organization of Student Representatives,

the Council of Teaching Hospitals and the Council of Academic Societies to consider issues relating to graduate medical education. The program was similar to one sponsored by the Council of Deans at its June meeting. Following up on these briefings, the Executive Council discussed the problem of maintaining sufficient residency positions for U.S. medical school graduates.

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

The Executive Council, along with the Secretary-Treasurer, Executive Committee and the Audit Committee, exercised careful scrutiny over the Association's fiscal affairs and approved a modest expansion in the general funds budget for fiscal year 1983.

The Executive Committee met prior to each Executive Council meeting and conducted business by conference call as necessary. During the course of the year the Executive Committee met with Donald Custis, chief medical director of the Veterans Administration Department of Medicine and Surgery, James Wyngaarden, director of the National Institutes of Health, Robert Rubin, assistant secretary for planning and evaluation, DHHS, and Congressman Edward Madigan.

### COUNCIL OF DEANS

The activities of the Council of Deans in 1981-82 were dominated by its two major meetings—the business meeting at the Association's annual meeting in Washington, D.C. and the spring meeting at Kiawah Island, South Carolina. In addition, the COD Administrative Board met quarterly to review items on the AAMC Executive Council agenda of significant interest to the deans and to carry on the business of the COD. More specific concerns were addressed by smaller groups of deans brought together by common interests.

At the program session of the annual business meeting, Donald L. Custis, chief medical director of the VA, introduced Medical District Initiated Program Planning, a strategic planning effort to curtail the centralization of authority within the VA and place greater responsibility at the local level for identifying and meeting essential priorities in an increasingly resource-constrained future. Murray Mitts, director of program analysis and development at the VA and Malcom Randall, director of the VA Medical Center in Gainesville, Florida further elaborated on the organization and process of MEDIPP. The business meeting also



considered several Assembly action items including election of institutional and distinguished service members and proposed bylaw and COD rules and regulation changes. Additional discussions centered on the role medicine, particularly academic medicine, needs to play in the problems faced by society, such as care for the elderly.

One hundred eight deans attended the March 28-31 spring meeting devoted to "Academic Medicine—Exploring the Tasks at Hand: Expanding Resources-Contracting Programs." Robert Blendon, vice president of the Robert Wood Johnson Foundation, provided a look at the economic and political climate for medicine, and AAMC President John A. D. Cooper discussed the status of medical education in the U.S. Reflections on the relationships of academic medicine and the profession were presented by Lowell H. Steen, immediate past chairman, American Medical Association Board of Trustees. Lattie F. Coor, president of the University of Vermont, Robert L. Friedlander, president of Albany Medical College, W. Donald Weston, dean at Michigan State University College of Human Medicine, and John Gronvall, dean at the University of Michigan School of Medicine, discussed strategies and programs of their institutions to introduce more efficient management, consolidate programs, and develop an experimental budgeting system. A perspective on strategies for developing philanthropy for institutional support was provided by J. Michael Mattsson, executive director of the Development Office at the University of Utah. Jeff Goldsmith, director, Office of Health Planning and Health Regulatory Affairs, University of Chicago Medical Center, presented an informative discussion about the future of academic medical centers in a price competitive market. The program concluded with a presentation by Donald L. Custis, chief medical director, Veterans Administration, setting out his plans and perspectives on the future of VA-medical school affiliations. The presentations stimulated much discussion among the deans.

The spring meeting began with an orientation session for new deans at which they were introduced to the AAMC leadership and staff and briefed on the Association's resources and programs. The business meeting included discussions of the AAMC work plan entitled "Strategies for the Future," consideration of a proposed National Medical Research Month, review of a preliminary report on medical school approaches to problems in student financial assistance, a suggested expansion of VA faculty retirement options, a report on academic information in the health sciences center, a progress report on the project to study the general professional education of physicians, and a

suggested expansion of the AAMC's data collection and reporting activities.

Additional agenda items included the proposed appointment of an *ad hoc* Committee on the Promotion of Ethical Standards in Research; the progress of the Regional Institutes on Geriatrics and Medical Education; the Clinical Evaluation Project; and AAMC position statements on the Small Business Innovation Development Act, the economic and social ramifications of biomedical research, and the impact of the President's FY1983 budget request on students' ability to finance their education.

Several items considered by the COD Administrative Board during its quarterly meetings deserve special note. The Board considered and endorsed a proposed Association response to the report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. It deliberated extensively on the development of an AAMC position on national health planning legislation. In addition, the Board offered its suggestions on the programmatic implications of the NIH budget.

Sections of the Council meeting during the year were the Southern deans, the Midwest deans, and the deans of new and developing community-based medical schools. The deans of private-freestanding schools conducted a special meeting session at the spring meeting.

#### COUNCIL OF ACADEMIC SOCIETIES

Two major meetings dominated the 1981-82 activities of the CAS, which now has 73 academic societies representing over 100,000 U.S. medical school faculty members and others from the basic and clinical science disciplines.

At the 1981 fall meeting, the CAS sponsored a plenary session and discussion groups on "Basic Science Education as the Foundation for Advanced Medical Practice." Frederick E. Shideman, chairman of pharmacology at the University of Minnesota, contrasted the content and scope of instruction in pharmacology in the past and present and speculated on future developments. Ruben Bressler, chairman of medicine at the University of Arizona, discussed the challenge for basic and clinical scientists to identify essential bioscience knowledge to be learned by students. Robert W. Berliner, dean of the Yale University School of Medicine, identified methods faculty might employ to develop the future physician's ability to assimilate and utilize new scientific developments. Small group sessions discussed the appropriate college preparation for medical school, the role of the basic scientist in clinical departments, rein-

## THE COUNCILS

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forcement of the basic sciences during clinical education, and identification of the essential scientific concepts for students.

The January Interim Meeting of the CAS was the best-attended meeting in the Council's 14-year history. Key congressional staff and executive branch officials were invited to participate in a public affairs symposium on "Biomedical Research: A Partnership Between the Federal Government and the Academic Medical Center." A plenary session began with a presentation by Bernadine Healy Bulkley, professor of medicine at the Johns Hopkins University School of Medicine, who discussed the development of academic medical institutions as the stewards of the biomedical research enterprise. John K. Iglehart, special correspondent to the *New England Journal of Medicine*, provided an informed observer's view of federal/public expectations for biomedical research. Assistant Secretary for Health Edward N. Brandt discussed the federal role in the biomedical research effort. Dr. Brandt cited diversity, independence, competitiveness, and the potential for cross-fertilization as the most significant attributes of the nation's biomedical research enterprise. Following the plenary session, small groups of CAS representatives and federal policymakers had an opportunity to discuss informally the future of the biomedical research partnership between the federal government and the academic community.

The CAS Administrative Board conducted the business that arose throughout the year during quarterly meetings held before each Executive Council meeting. At its April meeting, the CAS Board met with William F. Raub, NIH associate director for extramural research and training and Joseph Rall, deputy director for science at NIH, regarding the intramural and extramural research budgets and the peer review process. Mary Ellen Jones, chairman of biochemistry at the University of North Carolina, discussed the intramural peer review process from her perspective as a member of the Board of Scientific Counsellors of the National Heart, Lung and Blood Institute. The April meeting also featured a joint session with the OSR Administrative Board to discuss the role of student/faculty relationships in the nurturance of curiosity and creativity and the development of high ethical standards. At the June meeting of the Board, Barbara J. Culliton, news editor of *Science* magazine, reviewed the increase in industrial investment in academic science. In September, a joint meeting of the CAS, COTH and OSR Boards considered the need to maintain sufficient graduate medical education opportunities for graduates of U.S. medical schools.

The quarterly *CAS Brief* informed medical

school faculty about current issues in medical education. The Association's CAS Services Program assisted societies desiring special legislative tracking and office management services. Six societies participated in the program in 1981-82: American Federation for Clinical Research, Association of Professors of Medicine, American Academy of Neurology, American Neurological Association, Association of University Professors of Neurology and Child Neurology Society.

### COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals held two general membership meetings during 1981-82. The theme for the COTH general session at the fall annual meeting was "Implementing Competition in a Regulated Health Care System." The featured speaker was Walter J. McNerney, then president of the Blue Cross/Blue Shield Associations, who warned that the "public mood toward health spending is becoming more severe" and is likely to have a major impact on the way teaching hospitals and others do business. He saw providers looking toward "greater aggregation of services as a means to compete" and the health care industry becoming increasingly segmented and proprietary in nature. He suggested that teaching hospitals seek economies of scale, minimize regulation effects, find new sources of capital and new support for research, husband good management personnel, consider sharing teaching programs, restructure organizationally, and take innovative approaches to the delivery of health care.

The Fifth Annual COTH Spring Meeting was held May 12-14 in Boston. Attracting a record 225 chief executives and their associates, the meeting focused on the increasing competition among hospitals and other providers for patients, new programs and services, community support and financial resources. The meeting began with three papers describing major environmental features faced by hospitals. John Iglehart, special correspondent for the *New England Journal of Medicine*, addressed "The Washington Perspective: Political and Budgetary Expectations for 1983 and Beyond." He noted that the trends under the Reagan Administration have been encouraging competition and permitting the free market to take its toll, a reexamination of the limits of public benevolence and federal government responsibilities, and less government regulation and reduced taxation. He cautioned that teaching hospitals no longer live in a resource rich world and face increasing pressure to down-size and identify their component costs more specifically.

J. Robert Buchanan, then president of Michael Reese Hospital and Medical Center, addressed "Regulation, Competition, and Physician Manpower Projections: The Issues Before Us." Dr. Buchanan described the evolution of present national health policies and potential impacts of increased physician supply. Bruce C. Vladeck, assistant vice president at the Robert Wood Johnson Foundation and former assistant commissioner of health responsible for the New Jersey State Rate Setting Commission, spoke on "State Rate Review and Health Planning: Regulatory Alternatives to Competition." He began by stating that "the evidence accumulated has demonstrated that state rate regulation of hospitals works," and cited reports which found that the rate of hospital cost increase in the six states with mandatory state rate regulation had been 2-3% lower annually than in other states.

In a special presentation, Donald L. Custis, chief medical director of the Veterans Administration, discussed policy developments in the VA and their implications for the private sector. Other speakers included Scott S. Parker, president of Inter-Mountain Health Care, Inc., who spoke on "Not-For-Profit Chain Operations: Assessing Their Impact and Looking to Their Future;" Allen M. Hicks, chairman of the board of Voluntary Hospitals of America and president of Community Hospital of Indianapolis, who spoke on the VHA collective approach; Myles P. Lash, executive director of the Medical College of Virginia Hospitals, and Fred Munson, associate professor at the University of Michigan's graduate program in hospital administration, who addressed "Competition Confronting University Hospitals: Its Impact on Patterns of Governance;" Karl G. Mangold, president of the Fischer-Mangold Group of Emergency Physicians, whose presentation was entitled "Non-Hospital Based Competition: An Entrepreneurial View;" J.D. Epstein, principal in the Houston-based law firm of Wood, Lucksinger and Epstein, who discussed "Reorganizing for Operating and Financial Flexibility;" Jeff Goldsmith, director of planning at the University of Chicago Medical Center, who discussed the topic of "Marketing the Teaching Hospital's Products;" and Robert L. Biblo, president of the Health Insurance Plan of Greater New York, on "Negotiating with Teaching Hospitals: An HMO Point of View." The COTH Spring Meeting concluded with a summary and analysis of the various presentations and some personal commentary from Robert Zelten, associate professor at the Wharton School of the University of Pennsylvania.

The COTH Administrative Board met five times to conduct the Council's business and to review

and discuss Executive Council agenda items. A major agenda item continued to be the various "pro-competition" legislative proposals, their potential impact on teaching hospitals, and alternatives for addressing the issues. The Board neither formally endorsed nor opposed such legislation and specifically examined such relevant issues as Medicare and Medicaid participation, charity and uncompensated care, pricing of plans, a special fund for the societal contributions of teaching hospitals, and an evaluation commission. The Administrative Board also examined and endorsed in concept the American Hospital Association's proposed Medicare prospective payment system.

In other deliberations the Administrative Board focused on the AAMC's study of teaching hospital characteristics, the report of the Association's *ad hoc* Committee on Health Planning, the impact of proposed Medicare and Medicaid budget cuts and tax-exempt financing restrictions, the Health Care Financing Administration's regulatory proposal for prospective reimbursement of dialysis services, the declining availability of graduate medical education positions at teaching hospitals, and AAMC sponsorship of a capital purchasing program. Preceding three of its meetings, the Administrative Board held informal discussions with guest speakers. Harold Cohen, executive director of Maryland's Health Services Cost Review Commission, discussed the evolution and success of hospital rate setting in his state. Willis Goldbeck, executive director of the Washington Business Group on Health, reviewed developments in the area of business coalitions, employer self-insurance, and preferred provider arrangements. Paul Ginsberg, Congressional Budget Office deputy assistant director for income security and health, discussed CBO's evaluation of proposed Medicare and Medicaid budget reductions and an assessment of the American Hospital Association's prospective Medicare payment proposal.

#### ORGANIZATION OF STUDENT REPRESENTATIVES

As evidenced by attendance at regional spring meetings and by the leadership roles undertaken by OSR members within their institutions, the Organization of Student Representatives continues to grow both in numbers and influence. One hundred eighteen U.S. medical schools presently participate, and 95 sent student representatives to the 1981 annual meeting. Attendees shared experiences during discussion sessions on a wide variety of topics including student political activism and roadblocks to psychosocial development during medical school. They also heard presenta-

## THE COUNCILS

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tions on clinical evaluation and on the prevention of failure during medical education. The main program, "Tomorrow's Medicine: The Practice, The Economy, The Science," was presented by Alvin Tarlov, professor of medicine, University of Chicago Pritzker School of Medicine; Jeff Goldsmith, director, Office of Planning and Health Regulatory Affairs, University of Chicago Medical Center; and Jane Henney, special assistant for clinical affairs, National Cancer Institute. Also at the annual meeting the representatives passed seventeen resolutions to guide the deliberations of the eleven-member Administrative Board over the year.

The Board met prior to each Executive Council meeting to coordinate OSR activities and to consider Executive Council agenda items. During a special session in April the Administrative Boards of OSR and CAS met to share perspectives on the faculty's role in nurturing students' curiosity and in motivating adherence to high ethical standards. This was judged quite useful, and a joint annual meeting session for the memberships of both groups was planned. At each of its meetings the OSR Board heard progress reports on the General Professional Education of the Physician project and on the status of funding for student financial aid programs and for Medicare and Medicaid. The OSR Chairperson also shared updates on activities of the Consortium of Medical Student Groups, and progress was notable in overlap of goals and frequency of communications among the groups. Two areas to which the Board gave particular attention over the year were the problem of cheating in medi-

cal school and students' need for improved career counseling. At the 1981 annual meeting, OSR members completed a questionnaire regarding the former; results revealed skepticism about the utility of honor codes and a general paucity of activities to foster ethical behavior. The OSR Board explored ways to assist the schools in dealing with such issues. The Board also reviewed reports and descriptions gathered at regional meetings on dilemmas students face in the residency and specialty selection process and the kinds of assistance schools provide; methods to improve the quality and dissemination of available information were examined.

Activities in which all members of the OSR were invited to participate were numerous this year. The most important of these was the organization of massive letter-writing campaigns in early spring in response to the Reagan Administration's proposal to eliminate professional students' eligibility under the Guaranteed Student Loan program; Congress did not approve this proposal. OSR members also worked with student deans to institute housing-sharing services for seniors taking off-campus electives to prevent paying double rent and, at schools with upcoming LCME site visits, shared guidelines for input with other student leaders. Two issues of *OSR Report*, "Coming to Terms with Your Failed Expectations: a Non-credit Course for Physicians-in-Training" and "The Rising Costs of Health Care and the Responsibilities of Medical Students" were distributed to all medical students.

# National Policy

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The imperative to gain control over the economy continued to dominate the national policy scene this year. Presidential determination for spending cuts in virtually every budget category but defense funding was maintained at a high level. Consequently, pressure for retrenchment pervaded the 97th Congress as it closed its first and resumed work during its second session. Implementation of previously enacted reductions and the achievement of further cutbacks preoccupied the congressional schedule as fiscal austerity remained the central focus of federal policy.

Despite overall continuity, perceptible policy shifts did surface. The new thrust of turning federal responsibility back to non-federal sectors of society was strongly supported by the executive's "new federalism" proposal. However, the response of the legislature and the governors was wary and there was growing recognition that achievement of the general presidential goals of lower taxes, a lower deficit, increased defense spending, and preservation of essential non-defense programs was an impossibility.

Consistent with the centrality and pervasiveness of fiscal problems, budget and appropriations legislation preoccupied the attention of the Congress and hence of the Association.

Wrapping up the FY 1982 funding cycle proved to be arduous. As the start of FY 1982 approached, none of the necessary appropriation bills had been enacted. Consequently, as has become common, Congress passed what was to be the first of four temporary funding measures. The first continuing resolution provided for Department of Health and Human Services programs to be funded at the lower of their FY 1981 level or the amount in the House approved FY 1982 DHHS appropriation bill. The action effected funding reductions for virtually all National Institutes of Health programs of interest to the Association. The Veterans Administration was funded at the levels agreed to during the House-Senate conference on its FY 1982 appropriations bill, a measure providing a respectable increase in support for medical and prosthetic research.

In the meantime, President Reagan suddenly called for a reduction in FY 1982 spending 12% below the levels proposed in his March budget request. The Office of Management and Budget directed government agencies to keep their FY 1982 outlays to the reduced level, on the justification that the continuing resolution was a funding ceiling rather than a spending mandate. Since no formal deferral message was sent, this constituted an illegal impoundment of funds. In compliance, the NIH cut all awards and the VA research effort was severely curtailed.

Confusion deepened with the President's veto of the initial second continuing resolution which called for a 2% reduction in discretionary programs. Unable to override the veto, the Congress enacted a one month extension of the first resolution. The action prolonged a stalemate between a President, insisting on stringent fiscal restrictions, and a thin majority of the Congress trying to comply without wreaking severe damages on social programs.

Enactment of the third continuing resolution for FY 1982 only partially restored the President's 12% cut. It provided for funding of DHHS programs at the lower of the levels passed by the full House or approved by the Senate Appropriations Committee. In addition, it prescribed a 4% across the board cut that permitted reduction of up to 6% in certain individual programs. The action yielded a bare 2% increase over the FY 1981 NIH funding level and reduced the Alcohol, Drug Abuse and Mental Health Administration research and training functions below the FY 1981 level. A special provision mandating that the reductions were not to terminate any program slated for funding by at least one body allowed continuation of the Health Professions Student Loan program at the extremely modest House funding figure.

Under the third resolution, all NIH awards were issued with reductions averaging 4%, while earlier awards that had been cut by 12% received partial restoration to the new levels. The percent of approved competing awards funded fell as did the number of research trainees supported. Institu-

tional support for research training programs was cut by one-third to one-half.

For the VA, \$22.5 million was eliminated from the level agreed to in the conferenced FY 1982 VA appropriation bill, lowering support for VA research 8.5% below the FY 1981 figure.

Continued failure to pass some appropriations bills, including one for DHHS, eventually required a fourth continuing resolution. Enacted at the end of March, the final resolution simply extended the provisions of the third resolution to the end of this fiscal year. For the third successive year the DHHS operated under a continuing resolution rather than a normal appropriation.

An FY 1982 appropriations bill for the VA was eventually enacted, after being vetoed and revised in accordance with presidential design. Essentially, it provided support equal to that provided under the third continuing resolution.

Before FY 1982 funding was settled, the FY 1983 cycle got underway. The President's budget request for FY 1983 embodied the by-then familiar priorities of preserving the tax reductions enacted in 1981, reducing spending growth except in defense, and alleviating the federal regulatory burden. Although the President had announced an increase for the NIH, the actual amount proposed was far below that needed to keep pace with inflation. Particularly worrisome were a plan to limit indirect cost reimbursement on research awards to 90% of negotiated rates, a proposal to eliminate the eligibility of graduate and professional students for Guaranteed Student Loans, and further significant cuts in the Medicare and Medicaid programs. Only the VA came close to holding its own, with a proposed budget level close to its FY 1981 high. To implement his "new federalism" plan, President Reagan proposed to transfer to the states federal responsibility for welfare, food stamps, and various discretionary programs including some health block grants. In exchange the federal government would assume full responsibility for Medicaid.

The AAMC testified before the House Budget Committee on the President's proposed FY 1983 health budget to describe the scientific, social and economic benefits of biomedical research and warn that while the nation stands at the gates of the "age of biotechnology," it consistently underfunds the very research enterprise that will determine whether it retains preeminence in this important field.

When Congress set to work on the first budget resolution for FY 1983, the stalemates that characterized FY 1982 action reappeared. The Senate Labor and Human Resources Committee was not even able to reach a consensus to transmit recom-

mendations to the Senate Budget Committee.

Ultimately, the Senate approved a three-year freeze on non-military discretionary programs with a small add-on for health research and extensive Medicare and Medicaid reductions.

Passage of the first budget resolution did not meet statutory deadlines. At least six different substitutes for the House Budget Committee's plan, as well as some 70 amendments were presented. After four days of grueling debate, the House left town for its Memorial Day recess without a budget. On vote after vote, the two political parties and various loose coalitions failed to muster the needed support for any of the proposals. Finally, in mid-June, the House adopted by 13 votes a budget package similar to the Senate version.

The first budget resolution for FY 1983 emerged from conference containing a three-year freeze on non-military discretionary programs, a reduction in Guaranteed Student Loans, and substantial Medicare and Medicaid cuts. A measure of its lack of popularity was that it was approved in the House by a margin of two votes. Nonetheless, its passage sustained the momentum of presidential control of the budget process.

While the Senate moved ahead with a reconciliation measure proposing savings almost as great as were mandated, House action was chaotic. Democrats in the House Ways and Means Committee, anxious to avoid the stigma of increasing taxes or reducing social programs, prevented Committee action on a comprehensive proposal. The failure of the full House to do more than simply disapprove the Senate proposal, while agreeing to send members to a conference, created a legislative situation in which the House conferees had to act without specific instructions from the body they represented.

Meanwhile, the FY 1983 appropriations process had gotten underway with House and Senate hearings. Testifying before both Subcommittees on Labor/HHS/Education Appropriations, AAMC stressed the importance of increased funding for biomedical research, research training, student aid and health professions special projects. The subcommittees were especially urged to reject the proposed 90% cap on indirect cost reimbursement.

Testimony was also presented before the House and Senate VA Appropriations Subcommittees. AAMC urged the Congress to increase the FY 1983 expenditures for VA medical care and research beyond the maintenance levels advocated by the Administration.

While the funding levels for biomedical and behavioral research were being debated, a significant incursion into appropriations for those activ-

ities arose in the form of small business set-aside legislation. Touted as stimuli to economic growth, increased productivity and job creation, small business innovation development acts were introduced early in the Congress. Although the AAMC early opposed the legislation, widespread awareness of the dangers inherent in these measures did not appear until shortly before the Senate vote on S.881 embodying a 1% set-aside of extramural R&D funds. Testimony endorsed by the Association pointed out to the Senate Small Business Committee that the legislation would mean that rather than judging all applicants for NIH and ADAMHA grant support against a uniform standard of excellence, applicants from small business firms would be protected from competition with the rest of the applicant pool, establishing a dual standard for federal research and development funds at a time of diminishing support. Notwithstanding this argument, the bill passed the Senate unanimously in December.

In the House, several small business set-aside proposals eventually coalesced into a bill, H.R. 4326, mandating a 3% set-aside based on total agency R&D funds. Subsequent to Small Business Committee action, the Association, working with a number of other organizations, but especially closely with the Association of American Universities and the National Association of State Universities and Land-Grant Colleges, evolved a successful strategy to have the House bill sequentially referred to six other committees whose areas of jurisdiction would be affected. Thus, the legislation received what was probably the closest scrutiny of any bill in the 97th Congress. Members began to question its merits, and five of the six committees reported the bill with amendments to exempt specific agencies or substantially modify the set-aside proposal. The Committee on Energy and Commerce proposed an amendment to exempt all health-related research and the Veterans' Affairs Committee reported an amendment that had the effect of exempting the VA.

Although many members of Congress were sympathetic to arguments against the set-aside provision, the fact that it would enable the Congress to satisfy the large and powerful small business constituency without authorizing or appropriating new funds made its appeal virtually irresistible.

AAMC testimony before three House Committees—Energy and Commerce, Science and Technology and Veterans' Affairs—argued against the use of set-aside funds for either basic research or product development. The statements emphasized that a set-aside for basic research was unnecessary in light of small business eligibility for all federal research grant programs, and bad public policy as

it violated the principle of open competition based on merit. With regard to the use of set-aside funds for product development, the Association argued that federal assistance to bring products to market should more properly take the form of tax incentives, loan guarantees and other mechanisms consistent with the free enterprise system.

Despite the strategy of sequential referrals and the delays and substantial controversy opponents stimulated, the House passed a substitute measure reported by the Small Business Committee that lowered the set-aside from 3 to 1.25% of the extramural budgets of federal agencies. The Senate accepted the House version which provided a six year sunset provision and called for a General Accounting Office study of the program. Shortly thereafter the President signed the bill.

AAMC also devoted considerable energy to legislation regarding the use of animals in research. Although no action has occurred in the Senate, the House Subcommittee on Science, Research and Technology held a hearing on a number of bills. The most threatening would have required 30 to 50% of NIH's appropriations for research involving animals to be earmarked solely for the development of alternative research and testing methods.

The Association worked with the Subcommittee staff and succeeded in substantially modifying a long succession of draft bills. However, the proposal finally approved by the Committee still posed serious problems for the research community. H.R. 6829 requires compliance with accreditation requirements estimated to cost \$500 million within 10 years, without authorizing funds to assist institutions in complying. This bill has been referred to the House Subcommittee on Health and Environment where there will be some effort to modify the more onerous provisions.

In a related matter, the Association opposed an Administration proposal to transfer responsibility for inspection of animal facilities to the states and humane societies. Association testimony before the Agriculture Appropriations Subcommittees emphasized the need to retain federal control over such inspection to ensure that federally funded research is conducted under uniform standards. It also pointed out that there is no evidence that the entities cited in the Administration's proposal are authorized, willing or capable of assuming these important responsibilities.

Also in the area of biomedical and behavioral research, a major concern to the Association was legislation to reauthorize the components of NIH and ADAMHA. The House and Senate bills that emerged did more than simply renew expiring legislation and each contained a number of troubling provisions. While the House did not specifically

propose the authorization limits for all NIH institutes which generated so much controversy in the last Congress, language in the report accompanying the bill suggested that the issue was far from dead.

The original House bill underwent substantial expansion and modification during the period between its initial introduction and its approval by the Energy and Commerce Committee. Various components of the initial proposal were split off, amended and reintroduced as separate pieces of legislation. Ultimately, the Committee reported out four separate bills.

H.R. 6457, The Health Research Extension Act of 1982, to renew expiring authorities for the National Cancer Institute, the National Heart, Lung and Blood Institute, the Medical Library Assistance Act, and the National Research Service Award program, provided spending ceilings approximately 10% above the Administration's budget request. Although these levels were only 3-5% more than required to keep pace with projected inflation, retaining them through the unusually long series of markups was viewed as a victory in these austere times. Unfortunately, the bill was burdened with spending directives and study requirements in response to pressures from narrow special interest groups unconcerned with the overall health of NIH.

Particularly worrisome was the successful move to provide for a separate institute on arthritis and musculoskeletal diseases. The Association has long opposed creating new institutes because they decrease the flexibility with which the nation's research effort can be administered and establish dangerous precedents for the endless proliferation of narrow disease-specific organizations. Subsequent to acceptance of the arthritis institute amendment, the basis for the Association's latter concern became graphically clear. An immediate, although unsuccessful, attempt to provide for a separate diabetes institute followed and proposals for at least four other institutes are in the wings.

Other troublesome add-ons included provisions for dealing with scientific fraud, on peer review of contracts and intramural research, for a set-aside for the National Center for Health Care Technology, and for the transfer of the National Centers for Health Statistics and Health Services Research to the NIH.

Split off from the original bill were legislation to renew the National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse and a measure to transfer the National Institute on Occupational Safety and Health to NIH.

Testifying prior to Energy and Commerce Com-

mittee action on these proposals, the AAMC vigorously advocated the renewal of existing authorities, but recommended substantially increased authorization ceilings. The Association also urged that the proposed NIOSH transfer include only its research functions and that Congress specifically provide funds for the NCHCT rather than set-aside money from the already beleaguered NIH budget.

On the Senate side, the Biomedical Research Training and Medical Library Assistance Amendments of 1982 emerged with authorizations 3% above the Administration's FY 1983 budget proposals. The bill made some concessions to pressure for statutory mandates related to disease prevention, the peer review system, intramural research issues and the contract process. The Senate's approach used the mechanism of reports to Congress as opposed to the more rigid provisions in the House counterpart bill.

Testifying before the Senate Labor and Human Resources Committee, AAMC expressed reservations about the adequacy of the proposed authorization ceilings, noting that there has been a steady decline in U.S. investment in science, including biomedical science, that appears to be indicative of a retreat in the federal role in basic research.

The absence of provisions in the Senate bill for an arthritis institute was taken as an encouraging sign. However, under considerable pressure to consider the issue, the Labor and Human Resources Committee later held a separate hearing on a bill to establish such a new institute. As S. 1939 steadily picked up sponsors, including the Committee chairman, it became a virtual certainty that the bill would be added to the renewal legislation.

The outlook for student assistance darkened considerably this year. Consistent with the prevailing philosophy of fiscal austerity and the trend toward constriction of the scope of federal assistance programs, capitalization of the Health Professions Student Loan program was funded at half its FY 82 authorized level. The dearth of congressional support was particularly evident in the Senate Appropriations Committee proposal to terminate HPSL funding. Prospects for future HPSL funding were shadowed by congressional and press attention to HPSL debt collection problems. Following reports that a number of medical school graduates had been delinquent in repaying borrowed funds, the Senate Government Affairs Committee held hearings on the issue. The DHHS followed up by developing a strict HPSL collection policy that threatens to disallow lending by institutions whose students default on their loans at rates in excess of 5%.

The default issue also arose in connection with the



Health Education Assistance Loan, Guaranteed Student Loan, and National Direct Student Loan programs. Legislation was introduced to permit recovery of defaulted loans by offsetting the tax refunds of delinquent borrowers.

For the HEAL program, a more serious issue was a proposed restriction on borrowing limits. The Administration undertook to severely curtail the direct lending and loan guarantee activities of the government. HEAL was among programs targeted for credit limitations at a time when estimates of borrowing need were growing rapidly.

Simultaneously, the Administration proposed to terminate the eligibility of graduate and professional students for loans under the GSL program. Addressing a congressional panel on the impact of the President's FY 1983 budget request for higher education, AAMC emphasized that medical students from lower and middle income families have to borrow money from federal sources such as the GSL program if they are to pay for their educa-

tional expenses. Although the Congress did not implement this plan, legislation was introduced to increase the GSL interest rate for graduate and professional student borrowers.

In communications with Congress regarding student assistance, the Association emphasized the negative effects that funding reductions, arbitrary borrowing limits, and eligibility restrictions would have on the effort of medical schools to broaden the socioeconomic base of medical school classes. Also asserted was the need to ensure that medical students would be able to pursue their education in the reasonable certainty that assistance would be available until graduation.

As the 97th Congress winds to a close, several major issues remain unsettled. Appropriation bills are yet to be formulated for the FY 1983 funding cycle, various NIH and ADAMHA authorities still need renewal, and some further action is likely on animal legislation, at least in the House.

## Working with Other Organizations

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The Council for Medical Affairs—composed of the top elected officials and chief executive officers of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Council of Medical Specialty Societies, and the AAMC—continues to act as a forum for the exchange of ideas among these similar but diverse organizations. Among the topics considered during the past year were student financial assistance, prospective Medicare reimbursement, graduate medical education positions, and national health policy.

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

The accrediting process assists schools of medicine to attain prevailing standards of education and provides assurance to society and the medical profession that graduates of accredited schools meet reasonable and appropriate national standards; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated. Survey teams provide a periodic external review, identifying areas requiring increased attention, and indicate areas of strength as well as weakness. The findings of the LCME have been used to establish national minimal standards by universities, various government agencies, professional societies, and other organizations having working relationships with physicians.

The LCME, through the efforts of its profes-

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

In 1982 there are 127 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences. Three have not yet graduated their first classes and consequently are provisionally accredited; the 124 schools that have graduated students are fully accredited. Additional medical schools are in various stages of planning and organization. The list of accredited schools is found in the AAMC *Directory of American Medical Education*.

A number of new medical schools have been established, or proposed for development, in Mexico and various countries in the Caribbean area. These entrepreneurial schools seem to share a common purpose, namely to recruit U.S. citizens. There is grave concern that these schools offer educational programs of questionable quality based on quite sparse resources. While the LCME has no jurisdiction outside the United States and its territories, the staff has attempted to collect information about these new schools and to make such data available upon request to premedical students and their college advisors.

The Accreditation Council for Graduate Medical Education became financially independent this year. Before this, one-half of the operating costs for the ACGME were paid by the American Medical Association. Costs are now covered by revenues generated by charges for the accreditation process.

A memorandum of agreement for the provision of staff services to the ACGME by the American Medical Association was executed by the five sponsors of the ACGME (Association of American Medical Colleges, American Medical Association, American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies). The past year has seen the accreditation process improved and made more

effective.

The ACGME provides the opportunity for residency review committees (RRCs) to accredit programs in their specialty independent of review by the Council. RRCs granted independent accrediting authority must abide by the policies and procedures of the ACGME and submit their procedures and actions to periodic review by the Council. Thus far, ten RRCs have requested and been granted independent accrediting authority.

Additional accrediting responsibility for the ACGME has resulted from the establishment of an RRC in emergency medicine and the approval of the accreditation of subspecialty programs. The policies and procedures for subspecialty program accreditation are being developed.

The revised General Requirements of the Essentials of Accredited Residencies, approved in 1981, became effective July 1, 1982. To assist hospitals and program directors to develop policies and procedures in compliance with the revised requirements, the AAMC co-sponsored regional workshops with the American Hospital Association. The five one-day meetings were extremely well attended and indicated a high level of interest in the implementation of the revised requirements.

The new requirements provide the authority to the ACGME to set the standards for eligibility to enter accredited graduate medical education programs. In May 1982 the ACGME approved revised standards that allow graduates of LCME accredited medical schools and schools accredited by the American Osteopathic Association to enter graduate medical education without further examination or other requirements. However, graduates of schools not so accredited must pass a written examination acceptable to the ACGME for evaluation of cognitive skills. This examination will be required of all candidates wishing to enter accredited graduate medical education programs regardless of their citizenship. The ACGME noted that the present Visa Qualifying Examination is an example of a satisfactory examination. The Educational Commission for Foreign Medical Graduates has announced that such an examination is in development for implementation in 1984. A proposal by the AAMC that candidates passing that examination be required to pass an evaluation of their clinical skills by direct observation in prepared test centers has been referred to a special ACGME task force to determine feasible methods to accomplish such an evaluation.

The Accreditation Council for Continuing Medical Education continued its efforts to strengthen the accreditation process. Because of some changes requested by the AMA's House of Delegates, the Essentials still await final approval. Never-

theless, the relative simplicity and clarity of this document has aided the decision making process. By streamlining the review procedures and the policy making process, the ACCME was able to reduce the number of required meetings from three to one per year, a strategy which helped keep accreditation and policy costs at a steady level.

In a recent decision the ACCME adopted a definition or interpretation of continuing medical education that should be of interest to physician educators and administrators. According to this policy all educational activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are considered continuing medical education. This would include efforts to improve management practices and teaching abilities of the faculty.

In a drive to apply the new Essentials to the entire continuing medical education accreditation process, ACCME is actively engaged in strengthening its relationships with state medical societies now responsible for accreditation of organizations sponsoring continuing medical education largely for physicians within the state. Criteria and standards by which the ACCME will delegate this accreditation authority are under development.

The Educational Commission for Foreign Medical Graduates has responded positively to demands by the medical community, and notably the AAMC, to adopt a single examination for both alien and U.S. citizens who are graduates of foreign medical schools as a requirement for its certification program. A single, two-part examination now being developed jointly by the ECFMG and the NBME will be similar to the present Visa Qualifying Examination required for alien FMGs to obtain a visa. The ECFMG is also exploring various options for assessing the practical patient care skills of graduates of foreign schools either prior to or after acceptance into a graduate medical education program.

In the face of diminishing opportunities and resources for graduate medical education the ECFMG believes that opportunities for the education and training of alien graduates of foreign schools be directed primarily to the development of medical and academic leadership in foreign countries. This may require collaboration with the ACGME in reviewing graduate medical education programs that accept such FMGs.

The Coalition for Health Funding, which the Association joined with others in establishing 12 years ago, has expanded its activities and influence by monitoring and commenting on the development of the congressional budget resolutions in addition to its ongoing efforts on the appropria-

## WORKING WITH OTHER ORGANIZATIONS

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tions process. The unpredictabilities in the evolution of the congressional reconciliation process presented new challenges to the Coalition and emphasized the importance of cooperation among organizations with similar interests. Widespread acknowledgement of the usefulness of the Coalition's annual position on appropriations for the discretionary health programs offers significant evidence of the respect with which it is held.

The diversity of the Association's interests and the nature of its constituency offers an unusual opportunity for liaison with numerous other organizations representing health care providers, higher education, and those interested in biomedical and behavioral research. The Association is regularly represented in the deliberations of the Joint Health Policy Committee of the Association of American Universities/American Council on Education/National Association of State Universities and Land-Grant Colleges and in the Intersociety Council for Biology and Medicine. These liaison activities pro-

vide forums in which information on matters of national interest can be shared, varying points of view reconciled, and collective actions undertaken in the area of federal legislation and regulation.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with representatives of the educational and professional associations of other health professions. This year FASHP has been especially concerned about assuring adequate student assistance funds through the Guaranteed Student Loan program, the Biomedical Research Support Grant program of NIH, and proposed changes in the administration of the Health Professions Student Loan program. FASHP has also undertaken a major role in publicizing the Secretary's Award for Innovations in Health Promotion and Disease Prevention of the Department of Health and Human Services and will act as a selection committee for choosing finalists in the award program.

## Education

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The AAMC Teaching Institutes of the late fifties were the last time academic medicine embarked upon a study comparable in character and magnitude to the AAMC General Professional Education of the Physician project. This activity, sponsored by The Henry J. Kaiser Family Foundation, got underway in January when its Advisory Panel held its first meeting. Steven Muller, president of The Johns Hopkins University and The Johns Hopkins Hospital, is chairman of the panel, and William P. Gerberding, president of the University of Washington, is vice-chairman. The panel of eighteen members includes deans and faculty members from universities and colleges as well as medical schools and a private practicing physician. The panel's major goals are to assess the present approaches to the general professional education of the physician and college preparation for medicine and to develop recommendations and strategies to improve the effectiveness of instructional programs for the promotion of learning, and to stimulate broad discussions among the medical school and college faculties and their disciplinary societies about their philosophies and approaches to medical education and college preparation for medicine.

The greatest emphasis is placed on the stimulation of discussion among faculties, for the faculties of colleges and medical schools are ultimately responsible for selecting and teaching what students are expected to learn, and they also are responsible for setting the tone of the learning environment.

Subsequent to the first meeting of the project panel, a stimulus paper was prepared and widely disseminated to individuals responsible for the general education of the physician—the years that include college and medical school education. The response to this document indicated a high level of interest in the project.

The project progressed with the distribution of a booklet describing charges to three GPEP working groups to the Council of Deans, the Council of Academic Societies, the Council of Teaching Hospitals, the Organization of Student Representatives, the Group on Student Affairs, and the Group on Medi-

cal Education.

One GPEP working group, chaired by John Gronvall, University of Michigan Medical School, will consider the essential knowledge that all students should acquire during their general professional education. The group chaired by Victor Neufeld, director of the M.D. Programme, Faculty of Health Sciences, McMaster University, will consider those skills that all students should acquire during college and medical school to gain essential knowledge. The team led by Robert Kellogg, dean of the College of Arts and Sciences, University of Virginia, will describe the personal qualities, values, and attitudes that all physicians should possess. These GPEP working groups will meet during the next academic year.

Concurrently, 81 U.S. and Canadian medical school deans will organize institutional discussions by faculty, hospital staff, and students on the topics being considered by the working groups. In a corollary effort, 18 CAS professorial societies have organized disciplinary discussions on these subjects. Through these activities a broad range of those interested in medical education can engage in dialogues that will parallel those of the three working groups. Selected four-year colleges and universities will also participate in this phase of the project, which will conclude in May 1983. This three-year project will extend through the Association's 1984 annual meeting where a final report will be presented.

The GME has from the outset made a significant commitment to the GPEP project. Its 1981 spring regional meetings dedicated significant time to assisting in the identification of issues and alternate strategies for the emerging project. These were refined at sessions during the 1981 annual meeting and formed the basis for the report of its chairman to the GPEP panel at its second meeting. Members of the GME next see a role in facilitating local faculty consideration of the "Charges to the GPEP Working Groups," in preparing an institutional response, and in providing special comments both organizationally and individually as a community of educational scientists and persons with

day-to-day responsibility for the management of the educational program.

The GME will join with the GSA at the 1982 annual meeting in a discussion of the social, economic and political pressures affecting medical education. Issues that will be discussed include barriers to admission, impact on career development, influence on curriculum management, and the effect on faculty roles in the basic and clinical sciences. These and other topics will be treated in the educational exhibits, the miniworkshops, the small group discussions and the RIME papers and symposia.

The importance of linking improved quality of education to improved quality of patient care is at the core of the planning for intensified activity by the GME in continuing education. Sessions scheduled for the annual meeting concentrate on this goal by seeking ways to improve ties between the academic and practice communities and by considering approaches for incorporating principles of geriatric care in continuing education programs.

The RIME conference has been cited as a barometer of the level and kinds of concerns existing in the community. If this is valid, then the level of interest has intensified with the largest number of papers ever submitted being recorded for the 1982 conference. Admission to medical school, choice of residency and selection of residents, and needs assessment and program evaluation in continuing medical education were the areas of heaviest concentration.

Work has continued in the AAMC Clinical Evaluation Project. Staff has prepared a summary statement and accompanying background report on "Basic Issues in the Evaluation of Clerks and Residents: Perceptions of Clinical Faculty." These documents will be the basis for working with clinical faculty to enhance their understanding of issues in the evaluation of the performance of clerks and residents. They will also help to identify strategies for implementing the suggestions for change that emerge. The issues and proposals contained in these materials were generated from the responses of clinical faculty from over 500 departments and have been tested in a series of site visits. The next phase is the development and refinement of specific materials that will support efforts to improve the evaluation of clinical skills.

The MCAT Interpretive Studies Program, a cooperative effort with 30 member schools, continued to gain momentum. Several schools reported on their activities during the 1981 annual meeting. Most of the results discussed concentrated on performance criteria obtained during the first two years of medical school. Emphasis has subsequently shifted to the identification of appropriate

measures of clinical performance information. A summary was presented at each of the regional meetings of the GSA and at a symposium sponsored by the American Educational Research Association.

Meanwhile staff and contractor efforts to monitor and enhance MCAT test quality continued. A study of the content relevance of the science material on the test was completed, and a major project to explore subgroup performance differences was designed and initiated.

Along with these specific projects to improve quality, the Association continued its efforts to preserve the integrity of the test program from destructive governmental regulation. The AAMC continues its complaint against the state of New York in federal court and continues to offer the MCAT in New York only under the protection of a preliminary injunction. New York remains the only state to have passed such restrictive legislation. At both the federal and state levels a significant decline in interest in testing legislation was noted. This trend was supported by the report of the Committee on Ability Testing of the National Academy of Sciences, which found no justification for recommending governmental regulation of testing in either educational or industrial settings.

The continuing education systems project is now working with a number of institutions and organizations to test the validity and usefulness of the concepts and criteria of quality for improving the continuing medical education process. The products developed in this project have been helpful to other organizations developing their own procedures for assessing and improving the quality of their continuing education programs, including the Temple University Continuing Medical Education Consortium, the California Medical Association, the American Red Cross, the American Association of Dental Schools and the Veterans Administration. Other institutions are interested in changing particular aspects of the continuing education programs of their colleges. To strengthen this input, the continuing education systems project has now completed the preparation of manuscripts on needs assessment, program development and evaluation, and on promoting self-directed learning in continuing medical education. These learning packages will be produced by the Learning Resource Center of the Salt Lake City Veterans Administration Medical Center.

A seven-year collaborative project of the AAMC with the National Library of Medicine has concluded. During these years the AAMC assisted the NLM in developing AVLINE as an on-line, comprehensive database for audiovisual educational materials. The dimension and significance of the

database were enhanced by a critical review process that engaged over 2,000 faculty members in the review of catalogued items. While NLM is continuing the AVLINE database, it has discontinued its support for the critical review process. This represents a loss to those in health professions education, who consider the establishment of discriminating databases an important step towards realizing the future role of the medical library as an information center.

At the end of 1981 the Association undertook a new project to increase the understanding by officials and faculty of medical schools and teaching hospitals of the impact of the aging population on medical education and the delivery of health care. As its first effort the Steering Committee for the project developed a discussion draft describing the attitudes and basic and clinical sciences knowledge

that should be included in undergraduate medical education. This discussion draft was reviewed by participants at four Regional Institutes on Geriatrics and Medical Education held in spring 1982. Representatives from 88% of U.S. medical schools attended these sessions, which also featured small group discussions about models for geriatrics programs already in place in some medical schools. The Steering Committee and its consultants revised the document, "Educational Preparation for Improved Geriatric Care," after the discussions at the Regional Institutes. The project will conclude with a special general session at the 1982 AAMC Annual Meeting and the publication of the proceedings of the four Regional Institutes. This effort has been supported by the Pew Memorial Trust and the National Institute on Aging.

# Biomedical and Behavioral Research

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Along with the other agencies of the Department of Health and Human Services, the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration functioned for the third consecutive year without a formal appropriations law. The final continuing resolution for fiscal year 1982, passed by Congress in March, provided a level of funding sufficient for the NIH to support approximately 4,700 new and competing research project awards compared with 5,100 in fiscal year 1981. The ADAMHA budget supported approximately 214 new and competing project awards compared with 336 in 1981. The drop in the percentage of approved grants funded by NIH to below 35% has caused major concern in the academic community. In research training, the NIH supported approximately 9,700 trainees under the National Research Service Award program in FY 1982 compared with 10,700 in 1981 and ADAMHA supported approximately 1,070 trainees compared with almost 1,400 trainees in 1981. Allowances to the institutional sponsors of research training were reduced by 50%. The research programs of the Veterans Administration have also been constrained as the result of an 8.5% reduction in funding. The outlook for the 1983 federal research budget is not cause for optimism. The Reagan Administration's proposal to reimburse only 90% of negotiated indirect costs

associated with research grants would considerably erode the institutional base that supports research. There is understandable concern in the academic community that continued retrenchment discourages aspiring young scientists from the pursuit of careers in research.

The AAMC, with the endorsement of the Executive Council, has entered into the first phase of a national public relations campaign to heighten public awareness about the benefits to society of biomedical and behavioral research. More than 130 academic medical societies and voluntary health groups have been invited to participate in these activities. Their response has been overwhelmingly favorable. The Association has retained the services of a public relations firm to assist in developing a public relations strategy and the preparation of materials to be used in the solicitation of funds to support the campaign. After the strategy has been developed medical schools and teaching hospitals will be provided with core public relations materials that can be used to augment their local and regional activities. It is hoped that the public relations campaign can begin about January 1, 1983 and can be conducted at both the national and local levels during the year, building to a culmination in the fall of 1983 with either a presidential or congressional proclamation of a National Medical Research Month.



## Health Care

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The federal government has forecast that the number of Americans 65 and over will increase from 25 million in 1980 to 36 million in the year 2000 and 65 million by 2030. Within this population, the number of people 80 and over is projected to increase even more dramatically—nearly doubling from 5.2 million in 1980 to 10 million by 2000. This group, often referred to as the “old-old,” is more likely to need long term care due to a heightened risk of chronic diseases or conditions, or multiple health and social problems that limit their capacity for self-care. Long term care for such functionally impaired elderly encompasses a wide range of health and social services to prevent further disability, maintain current levels of function, and restore capabilities that have been lost.

The implications of these demographic trends on the costs and utilization of health and social services are staggering. However, these considerations are but one of several areas of concern regarding the future of long term care. Other currently recognized problems include fragmentation and lack of coordination of services, insufficient and inadequately trained health and social services providers, limited knowledge about aging processes and specific diseases and conditions affecting the elderly, and a paucity of community-based services to counter an overreliance on institutionalization.

During the past year, under a two-year cooperative agreement with the Administration on Aging, the AAMC continued to provide technical assistance to a group of Long Term Care Gerontology Centers. The centers are based in or affiliated with medical schools, and have been awarded grants for research, development of education and training programs and service models, information dissemination and technical assistance to address many of the problems in long term care.

Under the AoA-sponsored project, AAMC staff have identified field consultants to assist centers in both early and advanced stages of planning, conducted three workshops to address common organizational problems and suggest strategies for improving coordination among the centers, and developed a management information system to

gather aggregate data on the centers' activities for AoA. Through newsletters, workshop reports and *ad hoc* informational memos, the AAMC staff have also disseminated information on the research, education and training, and service models of the LTCGCs. In addition, a two-volume annual report described the collective accomplishments of the first five operational Long Term Care Gerontology Centers.

During the past year, the proceedings were published for a national conference co-sponsored by the AAMC and the Henry J. Kaiser Family Foundation on affiliations between academic medical centers and health maintenance organizations. The benefits and risks to both parties to these affiliations were explored. Case histories described various forms of prepaid practices, the different relationships that can exist, and the organizational, financial and educational considerations associated with these affiliations. *Health Maintenance Organizations and Academic Medical Centers*, available from the Kaiser Family Foundation, contains the major conference presentations and summaries of the participant discussions. This volume adds substantially to the body of knowledge on affiliations between prepaid plans and academic medical centers. In addition, three broad conclusions are made: there is a need for resources to support medical education in prepaid practice settings; large tertiary care hospitals will increasingly compete with secondary care community hospitals for prepaid practice patients; and relationships in which medical centers and HMOs retain a high degree of independence are advantageous to both types of organizations.

In related activity, the Association, in conjunction with the Department of Community Health of the Tufts University School of Medicine, currently is conducting a survey to identify the extent of undergraduate clinical medical education involvement at prepaid health care plans and the methods and data used to analyze the costs associated with medical education in these settings. This information is being sought in light of the pressures to expand prepaid health care plans and the growing

interest of academic medical centers in this method of delivering medical services.

The teaching of quality assurance and cost containment to undergraduate and graduate medical students and allied health professionals was the focus of two AAMC-prepared publications released in October 1982. The texts, *Quality Assurance and Cost Containment in Health Care: A Faculty Guide* and *Principles of Quality Assurance and Cost Containment in Health Care: A Guide for Medical Students, Residents, and Other Health Professionals*, offer faculty and curriculum planners numerous suggestions on facilitating the introduc-

tion of cost containment and quality assurance instruction into medical education and provide excellent materials for self-instruction. They also provide a systematic five-stage approach to conducting quality assurance and cost containment studies, using a methodology analogous to the stages of the clinical management of patients. In addition, the detailed case histories presented on quality assurance and cost containment studies conducted in actual delivery settings illustrate how the concepts and theories presented can be applied in practice.

## Faculty

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The leadership of the Association of American Medical Colleges has long been interested in broad issues of concern to faculty in the realm of scholarship, pedagogy, research, and research training. Research training for physician faculty, the apparent decline in the number of physicians entering research careers, and the difficulty of Ph.D. biomedical scientists in securing appropriate academic appointments are some of these concerns. To illuminate these problems, a number of relevant studies have been performed by the Association, sponsored by the National Institutes of Health and the National Academy of Sciences.

A study reported in March 1982 tested the conventional assumption that the majority of physicians engaged in research are members of medical faculties. Using the Association's Faculty Roster and the membership lists of twenty-four selected professional biomedical research societies, it was found that two-thirds of the physician members are now or were at one time on medical school faculties. On the other hand, more than half of the faculty members reported to the Roster as being engaged in research were not members of any of the twenty-four societies, even though a broad spectrum of research oriented societies was chosen, including all of the non-disciplinary general interest societies. Results of the study were distributed to presidents of CAS societies, the NIH, and the Committee on Biomedical and Behavioral Research Personnel of the National Academy of Sciences.

Another study reviewed the increasingly common practice of appointing Ph.D.s in clinical departments. The growth in opportunities in clinical departments comes at a time of diminishing appointments in the basic science departments. A surprising finding was that in 1978-79 more Ph.D.s were added in clinical than in basic science departments. In the aggregate, Ph.D.s in basic science departments outnumber Ph.D.s in clinical departments by only a little more than four to three.

The Faculty Roster System, initiated in 1966, continues to be a valuable database, containing information on current appointment, employment history, credentials and training, and demographic data for all 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. As of July 1982, the Faculty Roster contained information on 49,285 full-time salaried faculty and 1,837 part-time faculty. The system also contains 46,875 records for persons who previously held a faculty appointment.

Based on the Faculty Roster, the Association maintains an index of women and minority faculty to assist medical schools and federal agencies in affirmative action recruiting efforts. Approximately 300 recruitment requests from medical schools have been filled by providing the records of selected faculty meeting the requirements set by search committees. The only faculty records utilized in this service are those for individuals consenting to the release of their information for this purpose.

The Faculty Roster was also used to produce a report on the participation of women and minorities on U.S. medical school faculties in 1982.

The Association's *1981-82 Report on Medical School Faculty Salaries* was released in February 1982, presenting compensation data for 119 U.S. medical schools and 31,619 filled full-time faculty positions. The tables present compensation averages, number reporting, and percentile statistics by rank and by department for basic and clinical science departments. Many of the tables also allow comparisons according to type of school ownership, degree held, and geographic region. The periodic *Report on Medical School Faculty Fringe Benefits* was issued in July 1982.

# Students

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As of September 3, 1982 35,548 applicants had filed 332,997 applications for the entering class of 1982 in the 127 U.S. medical schools. These totals, although not final, represent a 3% decrease in the national applicant pool in comparison to the September figures for the 1981 entering class.

First-year enrollment increased from 17,186 in 1980-81 to 17,268 in 1981-82, while total enrollment rose from 65,189 to 66,298. Although the actual number enrolled is the largest ever, the 1.7% increase in total enrollment represents the smallest growth in the past ten years.

First-year enrollment of women medical students reached 5,317, a 7.1% increase since 1980-81, and the total number of women enrolled was 18,505, a 7.3% increase. Women held 27.9% of the places in the nation's medical schools in 1981-82 compared to 22.4% five years earlier.

First-year enrollment of underrepresented minorities equaled 1,671 or 9.7% of the 1981-82 first-year class; the total number of underrepresented minorities enrolled was 5,503 or 8.3% of all medical students enrolled in 1981-82.

The application process was facilitated by the Early Decision Program. For the 1982-83 first-year class 971 applicants were accepted by 68 medical schools offering such an option. Since each of these applicants filed only one application rather than the average of 9.5 applications, the processing of approximately 8,250 additional applications and scores of joint acceptances was avoided. In addition, the program allowed successful early decision applicants to finish their baccalaureate programs free from concern about admission to medical school.

Ninety-eight medical schools participated in the American Medical College Application Service to process first-year application materials for their 1982-83 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 Advisor Information Service circulates rosters and summaries of applicant and acceptance data to subscribing health professions advisors at undergraduate colleges and universities. In 1981-82, 246 advisors subscribed to this program.

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

The number of Medical College Admission Tests administered decreased 1% in 1981 from 49,646 the previous year. The decrease is more pronounced in the number of individuals sitting for the test for the first time. In 1981 there was a 5.6% decrease in first-time examinees while the number of repeating examinees increased by 9.8%. For the period 1978-81 the number of first-time examinees has decreased 11.7% accompanied by an 11.4% net increase in repeating examinees. Male examinees continue to represent a smaller proportion of the examinee group with decreases in 1981 occurring in both the number of first-time and repeating examinees. Although the percent of women examinees increased, the number of first-time women examinees actually decreased by 2.5% in 1981; the number of repeating women examinees increased by 14.5% over 1980.

The Medical Sciences Knowledge Profile examination was administered for the third time in June 1982 to 2,078 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC in the evaluation of individuals seeking advanced placement. While 5.2% of those registering for the test have degrees in other health professions, 87% of all registrants were currently enrolled in a foreign medical school. The total number of examinees for

the 1982 administration was 300 greater than in 1981.

Efforts continued to sustain the availability of financial assistance for medical students and to enhance the administrative expertise of medical school financial aid officers. Attempts by the 97th Congress to pass legislation that would impact on the substance and funding levels of federal financial aid programs available to medical students were carefully monitored. Testimony and written comments were delivered at each appropriate opportunity. Two workshops to improve the administration of financial aid at schools of medicine, osteopathy and dentistry were held during 1981-82. The grant from the Robert Wood Johnson Foundation supporting this activity will conclude with a program in Philadelphia November 17-19, 1982. The Association has also surveyed all medical schools about any innovative and successful student financing strategies and is exploring possible new sources of capital for student aid from the private sector. The Health Professions Student Loan program debt collection activities by the schools became a major issue. The Association worked closely with the schools and the Department of Health and Human Services to reduce the rate of delinquencies in the HPSL program.

The AAMC received a Health Careers Opportunity Program grant from the Department of Health and Human Services, Office of Health Resources Opportunity for three types of workshops to improve and develop effective programs for the recruitment and retention of students underrepresented in medical education. The Simulated Minority Admissions Exercise Workshop is for medical school personnel concerned with the admission and retention of minority students. The Retention and Learning Skills Workshop assists medical school personnel concerned with academic performance and retention of minority students. The Minority Student Financial Assistance Workshop is directed to student financial aid program administrators, financially disadvantaged students and premedical advisors to develop efficient and effective administration of financial aid programs. Additional workshops are planned for 1982-83.

The annual medical student graduation questionnaire was administered to the class of 1982 in 121 of the 123 medical schools with seniors. Approxi-

mately 11,000 students participated in the survey, a response rate of 67%. A summary report comparing national responses with individual institutional data was mailed to each school in September. Selected results appear in the 1982 Directory of the National Residency Matching Program.

The Graduate Medical Education Application for Residency, developed by the AAMC at the recommendation of its Task Force on Graduate Medical Education and distributed by the National Resident Matching Program, was employed for the second year. Applications were disseminated along with NRMP materials to medical school student affairs offices for use by students entering residency programs. The universal application facilitates the process of applying for a residency position by providing a standard form for transmittal of basic information from students to hospital program directors. Program directors may request supplemental information from applicants.

The inclusion in the "Recommendations of the AAMC Concerning Medical School Acceptance Procedures" of a provision that all schools offer sufficient places to fill their first-year classes by May 15 of each admission cycle was well received. This strategy to lessen the tension for both schools and students produced by the acceptance of large numbers of students during the summer months was used by virtually all schools in 1981-82.

The Group on Student Affairs-Minority Affairs Section continued to implement the recommendations of the AAMC Task Force on Minority Student Opportunities in Medicine. A major activity of the GSA-MAS was the Medical Careers Awareness Workshop for minority students. The workshop, held during the 1981 AAMC Annual Meeting, attracted over 200 student participants. Forty-one medical schools were represented. In addition, the GSA-MAS has planned projects in the areas of external examinations, graduate medical education, and faculty development.

Substantial progress was made on *U.S. Medical Students, 1950-2000: Trends and Projections*, with continued support from the Commonwealth Fund. A four-round Delphi Survey on the characteristics of future medical students was completed in December 1981 and will be incorporated in the book. Publication is scheduled for 1983 as part of the new AAMC Series in Academic Medicine.

## Institutional Development

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This year marks the tenth anniversary of the Association's Management Advancement Program, an effort to strengthen the management capabilities of medical school and academic medical center personnel. MAP continues to develop and conduct educational seminars, to analyze management issues, and to assist in identifying appropriate consultant services. To date fifty-four seminars have been offered; participants from 125 U.S. and 13 Canadian medical schools and 146 teaching hospitals have participated.

The program assists institutions in the development of goals that would effectively integrate organizational and individual objectives, to strengthen the decision-making and the problem-solving capabilities of academic medical center administrators, to aid in the development of strategies and mechanisms that would allow medical schools and centers the flexibility to adapt more effectively to changing environments, and to develop a better understanding of the function and structure of the academic medical center.

Again this year, emphasis has been placed on executive development seminars for senior academic medical center administrators, an intensive week-long seminar on management theory and technique. During the 1981-82 year there were three executive development seminars offered to medical school department chairmen. Participants included chairmen from departments of anesthesiology, medicine, obstetrics/gynecology, ophthalmology, orthopaedic surgery, pediatrics, psychiatry, and surgery. For the second consecutive year, a seminar focusing on the academic medical center/VA medical center affiliation relationship was conducted for VA medical center deputy directors as part of their professional development program. This program was sponsored with the Veterans Administration central office. Executive development seminars for deans, teaching hospital directors, and medical school department chairmen are planned for the coming year.

The Management Advancement Program was planned by an AAMC Steering Committee. Faculty

from the Sloan School of Management, Massachusetts Institute of Technology, have played an important role in the selection and presentation of seminar content. Consulting expertise has been provided by many individuals including faculty from Harvard University Graduate School of Business Administration, the University of Oklahoma College of Business Administration, the Brigham Young University, the University of North Carolina School of Business Administration, the George Washington University School of Government and Business Administration, and the Wharton School of the University of Pennsylvania. Initial financial support for the program came from the Carnegie Corporation of New York and the Grant Foundation. Funds for MAP implementation came primarily from the Robert Wood Johnson Foundation. The program is now supported by the Association and through conference fees.

In 1976 the Management Education Network was designed to identify, document, and transmit management information relevant to medical center settings. Supported by the National Library of Medicine, products from the MEN project include a study guide and companion audio-visual tapes on strategic planning, a study on medical school departmental review, a simulation model and companion study on tenure and promotion in academic medical centers, and a final report of the study of academic tenure.

In May 1982 the AAMC completed a two-year study sponsored by the National Library of Medicine. The report, entitled *Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management*, was approved by the Executive Council and published as a supplement to the *Journal of Medical Education*. The study involved site visits to ten institutions, meetings with many groups of health sciences librarians, an extensive review of the literature and the analysis of data from several surveys. William D. Mayer, M.D., president of the Eastern Virginia Medical Authority, chaired a nine-member advisory committee.

This is the fourth in a series of AAMC reports sponsored by the NLM to improve the quality of academic information management and transfer in academic medical center libraries. The report provides medical center administrators with a perspective on the electronic information transfer environment and the trends likely to affect the management of academic information by faculties, staffs, and students in medical centers. It is suggested that medical centers are poorly positioned to function effectively in an electronics-dominated, information-based society. A rationale for the long-range development of integrated institutional information networks is given. A series of scenarios describes the effects of newer information technologies on the flow of information and their uses by faculty members, staff and students. Two types of technologically sophisticated libraries are described. An argument is made that libraries can play a leadership role in introducing integrated information management networks into medical center settings.

Recommendations are addressed to three groups that will need to work together to bring about necessary changes in a timely fashion. Academic medical centers are called on to take the first steps towards information networks by strengthening the technological capabilities of their libraries. Pro-

fessional bodies are asked to assist medical centers to strengthen the interactions among education, research, and patient care through the incorporation of innovative information transfer systems into those processes. Public and private agencies are asked to share responsibilities for the costs of developing and supporting state-of-the-art information technologies to ensure a quality world biomedical information base.

Also completed and published in the fall of 1982 was a study titled *The Management of Information in Medicine: An Assessment of Applications of Technology, Policy Consequences, and Needed Changes in the Present System*. This study, sponsored by the Josiah Macy, Jr. Foundation, had three goals: an assessment of technological developments in information management applicable to the academic medical center functions of medical education, research, and patient care, and to the managerial functions which permit accomplishment of the tasks of the organization; the formulation of assumptions about the impact of future information management technological developments; and the identification of major policy issues for institution decision-making relating to the developments and changes needed in the present systems for managing information in light of likely developments in the area of information technology.

# Teaching Hospitals

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The Association's teaching hospital activities were concentrated on the Budget Reconciliation Acts of 1981 and 1982, proposed tax-exempt financing restrictions, health care competition, health planning, legislative and regulatory analyses, a major study of teaching hospital characteristics, and surveys and publications.

In August 1981 President Reagan signed the Omnibus Reconciliation Act of 1981, mandating overall federal spending reductions, including \$9 billion from the health component of the budget, through sweeping changes to both discretionary and entitlement programs. In relation to Medicare and Medicaid changes with potential impact on teaching hospitals, the positions advocated by the AAMC were supported on three critical issues. Despite considerable pressure from the Administration, the congressional conferees rejected a "cap" on Medicaid payments to the states. Instead, federal matching payments were reduced by specified percents in FY 1982 through 1984. However, several factors could decrease the costs in individual states. The House-Senate conferees also agreed to delete a House proposal requiring that interest earned on funded depreciation be offset against interest paid on capital indebtedness. In addition, separate rates for hospital-based and free-standing facility dialysis were required.

Enacted Medicare provisions included a reduction of the routine nursing salary differential to no more than 5%, a reduction of the section 223 ceiling for reimbursement of inpatient routine hospital costs, a limitation on the reasonable costs or charges for hospital-based outpatient services, and a requirement that HHS assess the performance of Professional Standards Review Organizations.

Strong support from the leadership of the Democratic Party and vigorous lobbying efforts by President Reagan enabled Congress to pass the "Tax Equity and Fiscal Responsibility Act of 1982" on August 19. Several spending reductions for the Medicare program are contained in this legislation, including elimination of the routine inpatient nursing cost differential, expansion of the

limits imposed on routine hospital costs (section 223 limits) to screen ancillary service costs as well as routine costs on a per case basis, and the creation of a second limit on hospital expenditures called a "target rate," under which hospitals will be severely penalized for exceeding the target or can share in the savings if their costs are reduced below the target. Payment to hospital-based physicians also will be curtailed under this law, and payments for physicians assisting at surgery are prohibited in hospitals with an approved residency program in the appropriate surgical specialty except under special circumstances.

Early in the FY 1983 federal budget process, the AAMC wrote President Reagan to strongly oppose proposals to cut \$950 million from entitlement programs through across-the-board reductions of 2% in Medicare hospital reimbursement and 3% in federal payments for optional services under Medicaid. The Association argued that these proposals would have a particularly adverse impact on the nation's academic medical centers and teaching hospitals, which provide a large proportion of care for the poor and the elderly. Responding to such opposition and to concerns about the potential for increased cost-shifting to private paying patients, congressional committees abandoned both proposals.

The AAMC's opposition to tax-exempt bond limits began even before the Administration submitted its budget request. Responding to remarks by Treasury Secretary Donald Regan, the Association wrote to request that the use of tax-exempt bonds by non-profit hospitals be continued. The AAMC joined with the Association of American Universities, the National Association of State Universities and Land-Grant Colleges, the National Association of Independent Colleges and Universities, and other higher education organizations to oppose restricting eligibility for both hospitals and educational entities. Key Congressmen were alerted about the devastating impacts that the proposed bond restrictions would have on non-profit hospitals, higher education and stu-



dents. They were urged to reject the Administration's position and endorse existing law regarding 501(c)(3) organizations and student loans in relation to tax-exempt bond use. This position was essentially contained in the tax reform legislation.

Several proposals to stimulate competition in the financing and delivery of health care were introduced in Congress during the past year. Although revenue savings from a health care competition proposal have been projected in the budget request submitted by the President both this year and last, no formal legislation has been proposed by the Administration.

In October 1981, the Association testified to the House Ways and Means Health Subcommittee on the major "pro-competition" bills. The Association emphasized that, "it is important to remember that there has been no wide-scale experience with these approaches. This is particularly significant because the proponents of price-competition among hospitals have not addressed the potential implications of these approaches for certain types of providers, patient populations, and the nation's supply of trained health manpower." For the teaching hospital to compete in a price-dominated marketplace, the Association explained that proposals would have to address funding for charity care patients and funding for the unique societal contributions of teaching hospitals, including the clinical component of undergraduate education, technology transfer, community-wide tertiary care services, and primary care ambulatory services in medically underserved areas.

Throughout the year, AAMC staff worked closely with the staff of Representative Richard Gephardt to find ways to address the teaching hospital's unique societal contributions within his "pro-competition" measure. At the request of the Congressman's staff, the AAMC obtained from the American Hospital Association's 1981 annual survey of hospitals an analysis of the charity and bad-debt deductions for the nation's short-stay, non-federal hospitals. The results were startling. Of all such hospitals in 1980, 5.6% (327) were non-federal members of the Association's Council of Teaching Hospitals. These COTH hospitals incurred 47% (\$601 million) of the charity care deductions and 35% (\$1.2 billion) of the bad-debt deductions for those hospitals. These data provided a clear measure of the special societal costs borne by teaching hospitals and underline the Association's concern that consumer choice/price competition proposals for restructuring health services pose a special risk for teaching hospitals unless improved financing is obtained for patients unable to pay for care. This concern, as well as others presented in the Association's earlier testi-

mony before the House Ways and Means Health Subcommittee, was voiced again by the AAMC at hearings conducted by the National Council on Health Planning and Development on "The Role of Health Planning in a Pro-Competitive Health System."

The position statement developed by the *ad hoc* Committee on Health Planning was approved by the Association's Executive Council in April 1982. In it the Association supported the concept of community-based health planning in an entirely new streamlined federal health planning law. The new statute should encourage the continuation of local health planning on a voluntary basis and mandate state certificate of need review at levels higher than in current law. The Association would not oppose limited federal technical assistance funding for the voluntary local planning component. Compliance with the CON mandate would require establishment of state legal authority for CON review and development of a state health plan, and would be enforced through withholding federal payments under certain health block grant programs. In addition, the revamped program must continue to give special consideration to the unique roles and needs of medical schools and teaching hospitals in fulfilling their patient care, education and research missions.

By May the AAMC had become a member of a coalition to promote a revised health planning program. This coalition worked to develop compromise legislation that would have broad bipartisan congressional support, and be acceptable to the Administration. After extensive negotiation, a compromise measure was developed which would repeal the current planning law and establish a health planning block grant in its place. States choosing to receive planning block grant funds would be required to develop state health plans and perform certificate of need review at thresholds higher than in present law.

During the year the Association responded to several proposed regulations or policy changes that would affect teaching hospitals participating in Medicare and Medicaid. The AAMC commented to the Health Care Financing Administration opposing a proposed rule to eliminate a regulation requiring states to announce Medicaid reimbursement changes 60 days before implementation. It was feared that the proposal would permit states to change Medicaid reimbursement without prior notification to providers. The Association felt it would be unfortunate if opportunities for public comment were eliminated solely to expedite administrative affairs and relieve short-term budget constraints.

The Association commented on a proposed revi-

sion to the *Medicare Provider Reimbursement Manual*, taking issue with proposed language to redefine seed money grants to include contributions only when they pertain directly to patient care services, establish a new provider, or enable an existing provider to furnish a new health care service. The Association urged that seed money contributions be allowed to assist any hospital operation in which Medicare shares in the allowable costs. It was emphasized that seed money contributions should also be allowed for establishing new residency programs and expanding existing patient care services. The Association also commented on a proposed "clarification" issued by HCFA for sections of the *Provider Reimbursement Manual*. The so-called clarification was believed to actually constitute a major substantive change in HCFA policy by eliminating payment to hospital associations for start-up monies invested in new membership service programs to reduce hospital costs. It was noted that such programs have included centralized purchasing services, group warehousing, management engineering consulting, combined laundry, and malpractice insurance activities. To avert a substantial barrier to such cost-effective innovations, the AAMC strongly recommended that HCFA withdraw its proposed changes.

In April 1982 the Association responded to regulations proposed by HCFA to establish a prospective payment rate for maintenance dialysis under Medicare's End-Stage Renal Disease program. These prospective payment rates would apply for such dialysis furnished at home or in a hospital-based or independent dialysis facility with rates paid to hospital-based facilities at a slightly higher level. In comments submitted to the HCFA Administrator and the House Ways and Means Subcommittee on Oversight, the AAMC emphasized the impact of the proposed payment regulations on teaching hospitals. The Association urged the subcommittee to recommend that HCFA suspend its plan to implement the proposed regulations until it developed a methodology for hospital-based dialysis which used up-to-date, accurate data and which accounted for the particular needs of hospitals and their patients.

On another occasion the Association wrote to HCFA on proposed revisions to the rules governing Medicare and Medicaid survey and certification of health care facilities. While applauding HCFA's efforts to simplify and streamline these regulations, the AAMC identified three areas in the proposed regulations where changes could further avoid unnecessary regulation, duplication and expense. It recommended that survey cycles should not be different for hospitals and their ex-

tended care facilities and nursing homes; that the confidentiality of hospital accreditation survey information be extended to their intermediate care and skilled nursing facilities; and that Joint Commission on Accreditation of Hospitals accreditation of providers be accepted for certification in both programs.

For the past two years AAMC staff has studied the characteristics of 33 members of the Council of Teaching Hospitals. The study provides a quantitative description of contemporary teaching hospitals. Under the guidance of the AAMC Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, the first two of three study reports were published in 1982. *The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report* presented data on patient case mix in 24 of the study hospitals using the "diagnosis-related groups" methodology developed at Yale University. *The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report* presented data on patient case mix in the same study hospitals using the "disease staging" methodology developed by Joseph Gonnella of Jefferson Medical College and others. Considerable time has also been devoted by the AAMC staff to drafting the final project report, which will include data on patient case mix, educational programs, facilities and services, research, hospital staffing, and financing of the participating hospitals.

Among *ad hoc* activities during the past year, the Association surveyed the Medicare documentation experiences of COTH members under the requirements of section 227 of the 1972 Medicare amendments which established special payment provisions for physicians' services provided in teaching hospitals. Additionally the AAMC evaluated proposed revisions to the medical staff chapter of the Joint Commission on Accreditation of Hospitals' *Accreditation Manual for Hospitals*.

The *COTH Report*, a comprehensive teaching hospitals issues-oriented newsletter, was published ten times during the past year. In addition to the newsletter, the Association maintained its program of regular membership reports and surveys. *The COTH Directory of Educational Programs and Services* was published for the 14th consecutive year, providing an operational and educational program profile of each COTH member. Other annual teaching hospital survey reports included the *COTH Survey of Housestaff Stipends, Benefits, and Funding*; the *COTH Executive Salary Survey*; and the *COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data*. Data extrapolated from these survey reports were included in datagrams appearing in the *Journal of Medical Education*.

# Communications

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The Association continues to make its views, studies and reports known to its constituents, federal officials and the general public with a variety of publications, news releases, memoranda and personal interviews with members of the news media. The AAMC responds to many and differing news media inquiries each day in addition to the news stories it generates. The Association report on "The Maintenance of High Ethical Standards in the Conduct of Research" has stimulated considerable media attention in both the lay and scientific press.

An important publication of the Association is the President's *Weekly Activities Report*, published 43 times a year and read by more than 7,500 individuals. It reports on AAMC activities and federal actions which directly affect medical education, biomedical research and health care.

The *Journal of Medical Education* in fiscal 1982 published 1,018 pages of editorial material in the regular monthly issues, compared with 1,045 pages the previous year. The published material included 84 regular articles, 64 communications, and 6 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 about 6,500, the same as in fiscal 1981.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1981-82 totaled 413, compared with 421 the previous year. Of the 413 articles received in 1981-82, 144 were accepted for publication, 206 were rejected, 17 were withdrawn, and 46 were pending as the year ended.

In addition to the regular monthly issues, two *Journal* issues included a special Part 2. The first was the final report of the AAMC's Task Force on Graduate Medical Education titled, *Graduate Medical Education: Proposals for the Eighties* and

the second was *Academic Information in the Academic Health Sciences Center: Roles for the Library in Information Management*. Six supplements (carried as part of the regular issues) were produced: "Continuing Education of Health Professionals: Proposals for a Definition of Quality," "External Examinations for the Evaluation of Medical Education Achievement and for Licensure," "Quality of Preparation for the Practice of Medicine in Certain Foreign-Chartered Medical Schools," "AVLINE: A Data Base and Critical Review System of Audiovisual Materials for the Education of Health Professionals," "AAMC Annual Meeting and Annual Report, 1981," and "The Maintenance of High Ethical Standards in the Conduct of Research."

About 24,000 copies of the annual *Medical School Admission Requirements*, 4,000 copies of the *AAMC Directory of American Medical Education*, and 8,000 copies of the *AAMC Curriculum Directory* were sold or distributed. Numerous other publications, such as directories, reports, papers, studies, and proceedings, were also produced and distributed by the AAMC. Newsletters include the *COTH Report*, with a monthly circulation of 2,600; the *OSR Report*, circulated twice a year to medical students; *STAR* (Student Affairs Reporter), printed twice a year with a circulation of 1,000; and *Council of Academic Societies Brief*, published quarterly for a circulation of 5,000.

Last year the Association and Jossey-Bass Inc., Publishers agreed to publish important contributions to the medical education literature in an AAMC Series in Academic Medicine. The first two volumes in the series, *Quality Assurance and Cost Containment in Health Care: A Faculty Guide* and *Principles of Quality Assurance and Cost Containment in Health Care: A Guide for Medical Students, Residents, and Other Health Professionals*, have now been published. Four other volumes are in process.

# Information Systems

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The Association's general purpose computer system continues to grow and the information systems continue to expand. The Association currently has three Hewlett Packard HP-3000 computers supporting over 80 terminals used by the Association staff and a high speed laser printer which can electronically generate forms and emulate the photo composition of documents as well as print the volumes of reports required to support the Association's information needs. In addition to comprehensive information systems focusing on students, faculty and institutions, the Association has significantly expanded its use of this facility in support of membership services.

The largest volume of information maintained by the Association focuses on individuals engaged in the pursuit of a medical education: applicants to, students in, and graduates of U.S. medical schools. A continuing effort is underway to organize more efficiently the information gathered during the examination - application - matriculation - graduation process and make it more readily available. This system serves as the basis for special reports generated throughout the year and provides answers to questions posed by medical school personnel and Association staff. It is used for regular descriptive studies of medical school applicants and issued-oriented studies.

The heart of the information on medical students is the American Medical College Application Service system. This system supports the Association's centralized application service by capturing data on applicants to medical school and linking applicant data with the MCAT test scores and academic record information for each applicant. Medical schools and applicants are informed of the application process through daily status reports, and medical schools regularly receive rosters of applicants and summary statistics comparing their applicants to the national pool. Each record is immediately available via computer terminal to Association personnel responding to inquiries from applicants and medical school personnel.

A number of other data systems supplement the AMCAS information on medical students. Among

these are the Medical College Admission Test reference system of MCAT score information for all examinees, a college information system on all U.S. and Canadian colleges and universities, and the Medical Sciences Knowledge Profile system on individuals taking the MSKP exam for advanced standing admission to U.S. medical schools.

The student records system has information on students enrolled in U.S. medical schools. This system, maintained in cooperation with the medical schools, follows medical students from matriculation through graduation. The information in the student records system is supplemented through the administration of surveys such as the graduation questionnaire and the financial aid survey to specific groups or samples of medical students.

The Association maintains two major information systems on medical school faculty. The Faculty Roster system includes information on the background, current academic appointment, employment history, education, and training of salaried faculty at U.S. medical schools. This information is maintained in cooperation with medical school staff by Association personnel having online access to update the information. Data in the Faculty Roster system are periodically reported to the medical school in summary fashion, enabling the schools to obtain an organized, systematic profile of their faculty. The faculty salary survey system contains information from the Association's annual survey of medical school faculty salaries. This information is used for the annual report on medical school faculty salaries and is available on a confidential, aggregated basis in response to special inquiries.

The Association maintains a number of institutional information systems, including the Institutional Profile System, a repository for information on medical schools. Information is entered both directly from surveys sent to the medical schools and through other information systems. The information is maintained in a database supported by a software package allowing immediate user retrieval via computer terminal. The system is used to re-

spond to data requests and to support research projects. There are over 20,000 items of information in IPS, describing many aspects and characteristics of medical schools from the early 1960s through the present.

An ancillary system to the Institutional Profile System has been developed to process Part I of the Liaison Committee on Medical Education annual questionnaire. This allows data input and on-line editing of the data, and generates reports that identify errors and inconsistencies in the data on the questionnaires and compare the values from the current year with those reported from the previous four years. This system produces information used in the report of medical schools' finances which appears in the annual education issue of the *Journal of the American Medical Association*.

Information on teaching hospitals is also maintained. The Association's program of teaching hospital surveys combines four recurring surveys with special issue oriented surveys. The annual surveys are the educational program and services survey, the housestaff policy survey, the income and expenses survey for university-owned hospitals, and the executive salary survey. These are the basis of four annual reports generated by the Association and provide answers to special requests made by the member hospitals.

The use of information systems to provide direct services to constituents has increased greatly during the past year. In addition to the Association's

membership system, through which labels are produced for the *Weekly Activities Report* and the *Journal of Medical Education*, a number of information systems have been developed to meet specialized needs of Association constituent groups. Information systems currently support the activities of the Council of Teaching Hospitals, the Group on Business Affairs, the Group on Institutional Planning, the Group on Medical Education, the chief undergraduate health profession advisors, the Council of Academic Societies and the women in medicine activities. These systems are used to produce labels for mailing to the groups, correspondence to selected members, and membership directories. An expansion of the Association's membership services information system to integrate the individual membership systems and incorporate such features as a rapid correspondence (mailgram) or electronic mail facility is currently under investigation.

Data collection and dissemination efforts continue to give attention to special areas of concern to medical education. Among the areas currently receiving attention are the validation of the Medical College Admission Test, the General Professional Education of the Physician project, and minority access to medical education. Association staff will continue to use all available information resources to illuminate these and other areas of importance to medical education.

## Treasurer's Report

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The Association's Audit Committee met on August 27, 1982 and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1982. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 9, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled \$11,420,422. Of that amount \$9,775,828 (86%) originated from general fund sources; \$591,711 (5%) from foundation grants; \$1,052,883 (9%) from federal government reimbursement contracts.

Expenses for the year totaled \$9,667,128 of which \$8,142,886 (84%) was chargeable to the continuing activities of the Association; \$470,276 (5%) to foundation grants; \$1,052,883 (11%) to federal cost reimbursement contracts; \$1,083 to Council designated reserves. Investment in fixed assets (net of depreciation) increased \$134,838 to

\$1,155,001.

Balances in funds restricted by the grantor increased \$91,628 to \$562,624. After making provisions for reserves in the amount of \$533,358 principally for special legal contingencies, housestaff meetings, investment in building and MCAT and AMCAS development, unrestricted funds available for general purposes increased \$757,344 to \$7,533,316, an amount equal to 78% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100% of the Association's total annual budget. It is of continuing importance that an adequate reserve be maintained.

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
BALANCE SHEET  
June 30, 1982

ASSETS	
Cash	\$ 191,053
Investments	
Certificates of Deposit	12,226,309
Accounts Receivable	580,907
Deposits and Prepaid Items	32,606
Equipment (Net of Depreciation)	<u>1,155,001</u>
<b>TOTAL ASSETS</b>	<b>\$14,185,876</b>

LIABILITIES AND FUND BALANCES	
Liabilities	
Accounts Payable	\$ 862,043
Deferred Income	1,169,403
Fund Balances	
Funds Restricted by Grantor for Special Purposes	562,624
General Funds	
Funds Restricted for Plant Investment	496,856
Funds Restricted by Executive Council for Special Purposes	2,406,633
Investment in Fixed Assets	1,155,001
General Purposes Fund	<u>7,533,316</u>
	<u>11,591,806</u>
<b>TOTAL LIABILITIES AND FUND BALANCES</b>	<b>\$14,185,876</b>

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
OPERATING STATEMENT  
Fiscal Year Ended June 30, 1982

SOURCE OF FUNDS	
Income	
Dues and Service Fees from Members	\$ 2,722,516
Grants Restricted by Grantor	591,711
Cost Reimbursement Contracts	1,052,883
Special Services	4,638,908
Journal of Medical Education	100,217
Other Publications	342,767
Sundry (Interest \$1,542,430)	1,971,420
Reserves	<u>1,083</u>
<b>TOTAL SOURCE OF FUNDS</b>	<b>\$11,421,505</b>

USE OF FUNDS	
Operating Expenses	
Salaries and Wages	\$ 4,266,833
Staff Benefits	661,535
Supplies and Services	3,611,082
Provision for Depreciation	281,630
Travel and Meetings	788,307
Loss on Disposal of Fixed Assets	1,454
Interest Expense	1,465
Provision for Contract Adjustment	<u>54,822</u>
<b>TOTAL EXPENSES</b>	<b>9,667,128</b>
Increase in Investment in Fixed Assets (Net of Depreciation)	134,838
Transfer to Executive Council Reserved Funds for	
Special Programs	533,358
Reserve for Replacement of Equipment	237,209
Increase in Restricted Fund Balances	91,628
Increase in General Purposes Funds	<u>757,344</u>
<b>TOTAL USE OF FUNDS</b>	<b>\$11,421,505</b>

# Treasurer's Report **AAMC Membership**

	1980-81	1981-82
Institutional . . . . .	123	123
Provisional Institutional . . . . .	3	4
Affiliate . . . . .	16	16
Graduate Affiliate . . . . .	1	1
Subscriber . . . . .	18	16
Academic Societies . . . . .	71	73
Teaching Hospitals . . . . .	410	416
Corresponding . . . . .	28	31
Individual . . . . .	1301	1300
Distinguished Service . . . . .	52	51
Emeritus . . . . .	50	47
Contributing . . . . .	4	4
Sustaining . . . . .	12	12



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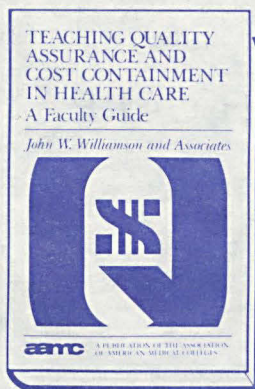
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**Association of American Medical Colleges  
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**TEACHING QUALITY ASSURANCE AND  
COST CONTAINMENT IN HEALTH CARE**  
A Faculty Guide

Quality assurance and cost containment — the systematic assessment of the effectiveness and cost-efficiency of services — is rapidly becoming an integral function of modern health care. But there are virtually no standardized resources for training current and future practitioners in quality assurance techniques. To fill

this need, the Association of American Medical Colleges inaugurates its Series in Academic Medicine (edited by John A. D. Cooper) with this new book, a comprehensive guide to teaching quality assurance and cost containment in health care. It is designed as a broadly based teaching resource for professional school faculty as well as for health care administrators and practitioners who want to make quality assurance part of their own practices.

The authors draw on their wide range of professional experience for in-depth treatment of the theory methods, and applications of quality assurance and cost containment. They show how this knowledge can be introduced in undergraduate, graduate, and continuing education programs. And they detail all the information needed to conduct quality assurance studies, including selection and use of statistics, assessment techniques, and strategies for improving care delivery. To facilitate both teaching and learning, chapters are built around case examples, statistical resources, research studies, and projects for assignment. All material on the quality assurance process was tested in eight medical schools, then further refined for greater clarity and usefulness.

**USES OF THIS BOOK**

This volume will be a valuable resource for medical, nursing, allied health, mental health, and health-related instruction — at both preprofessional and professional levels in hospital or clinical programs, residencies and other internships, and workshops as well as classrooms. Administrators and practicing professionals interested in setting up their own quality assurance programs will find this book helpful as a self-teaching aid and as a guide to training their own quality assurance staffs. The concepts presented are applicable to all settings — hospitals, clinics, health maintenance organizations, public and private agencies, and private practices. This book can be used by itself or with a companion volume, *Principles of Quality Assurance and Cost Containment in Health Care* (see reverse panel).

**DESCRIPTION OF CONTENTS**

**Part One** offers advice to faculty on developing a quality assurance and cost containment curriculum. *Chapters One through Three* show how to plan and implement a curriculum that is structured around major quality assurance issues, how to integrate quality assurance concepts and activities into successive levels of training, and how to evaluate the success of the curriculum in regard to learners' needs, program goals, professional attitudes, and care delivery.

**Part Two** presents the content of a quality assurance curriculum and the basic tools of quality and cost studies — that is, core concepts and information essential to using quality assurance procedures. *Chapters Four and Five* focus on health problems as the key to establishing quality assurance priorities; explain ways to gather data on frequency, health loss, and economic costs of health

problems; and then show how these factors determine which problems warrant quality assurance study. *Chapters Six and Seven* discuss *efficacy* (maximum effects of care achieved under ideal circumstances) as a prerequisite for measuring the effectiveness and cost efficiency of interventions; they also describe specific ways of documenting efficacy and evaluating the effectiveness and efficiency of care.

*Chapter Eight* reveals how the information in Chapters Four through Seven is used to diagnose needed improvements in current care and to assess the extent to which improvements can be achieved with available resources; it also suggests ways to improve provider performance, patient compliance, and organizational functioning. *Chapters Nine and Ten* outline a five-stage approach to quality assurance and cost containment and illustrate it in a detailed case study that highlights major concepts and methods.

**Part Three** addresses current trends and future needs in quality assurance education. *Chapter Eleven* compares quality assurance programs in fourteen academic institutions, focusing on program objectives, length, content, and evaluation results. *Chapter Twelve* spells out the need for increased quality assurance research in such areas as long-term care, ambulatory care, and risk management.

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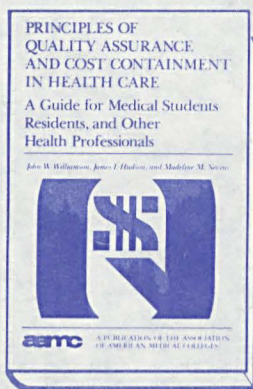
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Association of American Medical Colleges  
Series in Academic Medicine



John W. Williamson, James I. Hudson,  
and Madeline M. Nevins

PRINCIPLES OF QUALITY ASSURANCE  
AND COST CONTAINMENT IN HEALTH CARE  
A Guide for Medical Students, Residents,  
and Other Health Professionals

More than ever before, the health professions are under pressure to control the costs of today's increasingly complex health care. But health care at reduced costs may not be cost-effective care. To ensure health care quality, practitioners need special expertise to answer such questions as: *Is current care achieving desired ends? Where are improvements needed? Are real improvements possible? Can the same care be provided with fewer resources? Will proposed reductions be cutting waste or substance? When are new methods worth increased expense? What risks are attached to them?* This new book — an inaugural publication in the Association of American Medical Colleges' Series in Academic Medicine (edited by John A. D. Cooper) — provides the background for that expertise. It is a concise but comprehensive introduction to quality assurance and cost containment — what it means, why it is important, and what skills are required. Designed for both beginning and practicing professionals, this book explains in clear, nontechnical language what knowledge is needed to answer the critical questions.

The authors delineate basic concepts in systematic studies of quality and costs, along with the types of information required for such projects. They show how such information is obtained and used to measure the effectiveness and efficiency of current care, as well as to identify what new care is needed, and what improvements are feasible. Case examples highlight the best methods in each stage of assessment and improvement. Many helpful aids — in the form of self-testing exercises and lists of additional resources — facilitate *self-learning* of these quality assurance principles. To increase the usefulness of this book to students and practitioners, the authors tested this material in eight medical schools and then refined it further for maximum effectiveness.

USES OF THIS BOOK

This volume is an ideal introductory guide to quality assurance for learners at all levels of medical, nursing, allied health, mental health, and health-related instruction. It can be used in classrooms, workshops, continuing education programs; in hospital or clinical training; and in residencies and other internships. And its broadly based approach offers health care administrators and practitioners in whatever type of settings — including hospitals, clinics, health maintenance organizations, public and private agencies, and even individual practices — a basic tool for continued self-learning. The book can be used alone as a general introduction to quality assurance and cost containment or in conjunction with a companion AAMC volume, *Teaching Quality Assurance and Cost Containment in Health Care* (see reverse panel), which contains more detailed, how-to-do-it information. Together, the two books serve as a comprehensive resource for setting up quality assurance programs in health care practices and for training students, practitioners, and health care staff in quality assurance procedures.

DESCRIPTION OF CONTENTS

Foreword, John A. D. Cooper, M.D., Ph.D. (AAMC)

Chapter One: Importance of Quality Assurance and Cost Containment in Current Health Care assesses the role of quality assurance in current and future health care; examines growing social and professional concern about the costs, benefits, and inequalities of health care; explores what impact legislation,

reimbursement methods, and increased competition among care providers has on efforts to make quality and cost assessment part of health practice; and describes an approach to quality assurance suited to the health professions because it utilizes familiar clinical techniques.

Chapter Two: Knowledge Base for Quality Assurance and Cost Containment discusses core areas of knowledge required for assessing and improving care; gives reasons for organizing studies around the health problems encountered in the setting; and traces the process of selecting problems for study on the basis of their frequency and associated costs. It explains how data on the efficacy (maximum achievable benefits) of an intervention is used to measure the effectiveness (benefits currently being achieved) and efficiency (amount of resources being utilized) of current care, and it details ways to evaluate effectiveness and efficiency.

Chapter Three: Identifying the Potential for Improvement in Health Care analyzes methods for identifying and implementing improvements; points out factors that determine to what extent improvements are achievable in each component of the health care encounter — practitioner, patient, and organizational structure; and advocates ways to strengthen human performance and organizational functioning by drawing on theories and techniques from other fields, including business and education. Basic quality assurance concepts are then reviewed in a case history, with exercises to test comprehension.

Chapter Four: A Five-Stage Approach to Quality Assurance and Cost Containment Projects shows how assessments are conducted in actual settings; describes a problem-oriented, team approach to quality assurance; and examines each of five stages — health problem analysis, topic selection, definitive assessment and improvement planning, implementation of improvements, and evaluation of results. It also compares the tasks in each stage to basic methods of health diagnosis and treatment; discusses the diverse responsibilities of team members, giving reasons for decisions, choice of methods, and conclusions; notes the resulting improvements, savings, and new costs; and includes further test exercises.

RESOURCES

The authors list the best sources of published and unpublished information on health problem importance and on efficacy, effectiveness, and efficiency of health care (*A: Sources of National and Local Data on Health Problems*, *B: Federal Sources of National Data on Efficacy*, *C: Sources of National Data on Results of Effectiveness and Efficiency Studies*). Addresses of organizations that produce such information are included, as are notations of publications and indexes useful in quality assurance studies. In addition, helpful materials on individual and organizational behavior are cited (*D: Selected Bibliography on Learning Theory, Behavior, and Organizational Change*), and sources of reports of major quality assurance studies are provided (*E: National Data on Cost-Benefit of Quality Assurance Activities*).

THE AUTHORS

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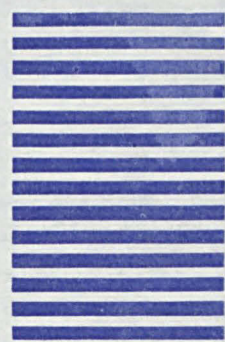
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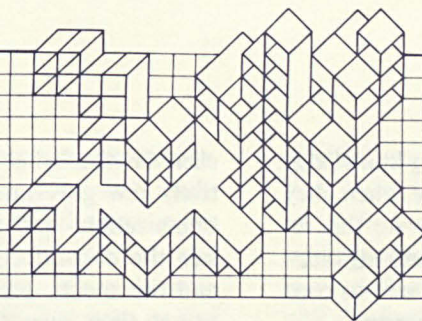
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## The General Professional Education of the Physician and College Preparation for Medicine

The general professional education of the physician spans the education acquired in college and in medical school. This general professional education is differentiated from specialized professional education, which is acquired following graduation from medical school. Rapid changes in biomedical knowledge and technology and the organization of medical care are in progress and advancing at an accelerated pace. **The Association of American Medical Colleges believes that medical education must be adapted to these changes if future physicians are to be equipped to cope with a dynamic, scientific profession upon which the public places the responsibility for its physical and mental health and to which the public is entrusting an ever increasing share of its resources.**

For this reason, the Association of American Medical Colleges has undertaken a three-year project, supported by a grant from the Henry J. Kaiser Family Foundation, to review and appraise the general professional education of the physician and college preparation for medicine. An 18-member panel comprised of individuals drawn from four-year colleges and universities, from U.S. and Canadian medical schools, and from the practice of medicine, heads this effort. Steven Muller, Ph.D., President of the Johns Hopkins University and the Johns Hopkins Hospital, is Chairman of the panel, and William P. Gerberding, Ph.D., President of the University of Washington, is Vice-Chairman.

**The project has two purposes:**

- **To assess the present approaches to the general professional education of the physician and college preparation for medicine and to develop recommendations and strategies to improve the effectiveness of instructional programs for the promotion of learning; and**
- **To stimulate broad discussions among the medical school and college faculties and their disciplinary societies about their philosophies and approaches to medical education and college preparation for medicine.**

The greatest emphasis is placed on the stimulation of discussion among faculties, for the faculties of colleges and medical schools are ultimately responsible for selecting and teaching what students are expected to learn, and they also set the tone of the learning environment.

### Project Concerns

After considering a broad spectrum of concerns about the general professional education of the physician and college preparation for medicine, the panel has concluded that to adapt their educational programs to future physicians, medical school and college faculties face four major challenges:

- The rapid growth of knowledge applicable to the care of patients and the treatment of disease;
- The ascendancy of complex technology and procedures in the diagnosis and treatment of patients with overt or potential disease;
- The coalescence of physicians, other health professionals, and hospitals into complex systems, which is paralleled by a concentration of the financial support for medical care in governmental and private agencies; and
- The mounting evidence that physicians are having difficulty coping with the rapid progress in medical care and in adapting to demands placed upon them by their patients and by the profession.

### The Growth of Knowledge

There is a broad consensus that the rate of growth of biomedical knowledge and its application to medical care will increase. The growth and differentiation of knowledge has caused scientists and physicians to specialize in order to pursue knowledge in depth and to apply it more effectively. New knowledge displaces old and new applications supplant previous approaches. All physicians

must be prepared to keep pace with advancing knowledge and to apply advances that are unforeseeable when they are students in college or medical school. To do this requires that students attain the skills, values, and attitudes of learned men and women that will enable them to continue to learn throughout their professional careers.

The panel believes that both college and medical school faculties are currently submerging students in overwhelming detail and that this submersion is antithetical to the development of the scholarly skills and attitudes necessary for continued learning. Great effort must be made to differentiate what must be learned at each stage as students progress from college through medical school and on into their specialized graduate medical education. This differentiation should result in a reduction of the degree of detail that students are expected to learn during their general professional education and should provide an educational milieu that teaches and reinforces scholarship.

### **The Ascendency of Technology**

Paralleling the growth of knowledge, technological inventions for facilitating the diagnosis and treatment of disease have developed rapidly. The application of these inventions to the care of patients has vastly increased the ability of physicians to diagnose and treat diseases on the basis of cellular, subcellular, and even molecular abnormalities and dysfunctions. Their introduction and availability has also enhanced the motivation to specialize. There is concern that in the future physicians may predominantly function as highly skilled, narrowly specialized technologists who are unable or unwilling to deal with the myriad problems and expectations that patients present.

The panel believes that all students must learn to interview and listen to patients and examine them using basic instruments. In the process of this learning, they should develop sensitivity for the unique qualities of each human being and learn that physicians are accorded trust and confidence that goes beyond their technical ability.

The panel believes that during their clinical education students' acquisition of basic clinical skills is insufficiently emphasized by faculties. The emphases are on specialized knowledge and the application of sophisticated technology, both of which are essential for patient care but detract from students' learning the fundamental skills that all physicians should have.

### **Coalescence Into Systems and Concentration of Support**

In the future, physicians will be involved in large organizational systems, and their services and the services they

elicit on the behalf of patients will be paid for by relatively few governmental and private agencies. Both the organizations and the sources for payment will emphasize the cost-effective utilization of available diagnostic and therapeutic techniques. Rather than being privileged to set their own fees and make decisions for patients without regard to cost, future physicians will have to practice within organizational constraints while still providing the care each patient needs.

The panel believes that medical students must learn to conserve resources. They must acquire both the knowledge and the skill needed to solve clinical problems as efficiently and cost-effectively as possible while attending to the unique needs of each individual.

Physicians' involvement in systems for medical care will also engage them in interacting with other health professionals. These cooperative interactions will be for the purpose of providing maximum benefit to patients. The panel believes that medical students should learn to work effectively with other health professionals and understand and respect their knowledge and skills.

The medical schools and teaching hospitals will also have the resources available to them constrained by these changes in the organization of the medical care system. These institutions and their faculties will be expected to teach medical students and residents and care for patients with externally imposed resource limitations.

### **Difficulty Coping**

It is likely that in the future physicians will be even more challenged than they are now by the rising expectations of a public better informed in sophisticated medical care. Keeping abreast of advancing knowledge, practicing within externally imposed constraints, and making ethical judgments that will be subjected to critical review will require that physicians learn healthy methods of coping with stress.

The panel believes that students must know and understand the stresses to which physicians are subjected. Faculties must be sensitive to signs of maladaptation to stress by students and must intervene to assist them to develop healthy approaches to coping with stress.

### **Two Ancillary Concerns**

The panel has two ancillary concerns about medical education.

- *The Relationship Between Medical Schools and Universities.* Universities are becoming an aggregation of specialized educational and research institutions whose faculties perceive their missions and responsibilities as

unique and unrelated to other faculties and students in the university as a whole. In most universities with medical schools, medical students are isolated from other schools and colleges. Their courses are planned and taught almost exclusively by the medical school faculty, and that faculty has little contact with the faculties or students of other schools. The panel believes that medical schools are properly located in our universities, but it also believes that medical education should be more integrated within the universities. Access to medical school courses should be accorded to students from other schools, and medical students should be privileged to study in other units of the university as well. If medical schools will assume leadership in reversing the trend toward isolation, the university and the schools will be strengthened.

- *Decline in Medical School Applicants.* For twenty years U.S. medical schools have had a surfeit of applicants. From a peak of 42,600 applicants for 15,000 positions in 1974, the number has fallen to below 36,000 applicants for almost 17,000 positions in 1982. This decline is expected to continue and even accelerate. The college age population will fall between now and 1990. In addition, the widening public discourse about a future surplus of physicians, the escalating burden of costs and debts that medical students are expected to shoulder, and uncertainties about the effect of changes in the organization and payment for medical care are likely to dissuade students from the study of medicine. Medical school faculties, rather than having to choose those they consider the best from among many applicants, may have to recruit capable students to enter medicine. Educational programs and procedures and policies for evaluation, promotion, and graduation will be affected by this change, and the cost borne by students will have to be adjusted if well-qualified students from all socio-economic levels are to be attracted to careers in medicine.

## Project Strategies

### Communications with Faculty

Throughout the project, an attempt is being made to stimulate discussions among faculties of the colleges and the medical schools by the dissemination of discussion documents to faculty, by engaging faculty participation in the project through institutional and disciplinary discussions, and through regional hearings.

When the panel held its first meeting in mid-January, it focused on three areas of concern in the eight-year period under study: the clinical education of the

medical student, the preclinical (or basic science) education of the medical student, and the four years that precede the student's entry into medical school, i.e., the undergraduate or college years. Following these discussions, a 60-page stimulus paper, *An Overview of the General Professional Education of the Physician and College Preparation for Medicine and Questions That Should be Addressed*, was developed. This paper was disseminated to 6,500 key individuals responsible for these three phases of the general professional education of the physician: administrators in colleges, universities, medical schools, and teaching hospitals; faculty in medical schools and teaching hospitals; student advisers; and medical students. An additional 3,500 copies of this publication were distributed upon request.

### Working Groups

At its second meeting, the panel defined three domains to which it wished to have working groups appointed. These were (1) Essential Knowledge, (2) Fundamental Skills, and (3) Personal Qualities, Values, and Attitudes. The following charges were framed to guide the working group deliberations:

*The Working Group on Essential Knowledge is charged to consider the knowledge that all students must acquire to provide the foundation for later specialized education and for continued learning throughout their professional careers and to describe approaches faculties might adopt to distinguish this knowledge base from that attained in specialty educational programs or in programs of study leading to advanced degrees in disciplines relevant to medicine.*

*The Working Group on Fundamental Skills is charged to consider those skills that all students should acquire during college and medical school to gain essential knowledge; to adapt to the need for continued independent learning; to obtain, assess, and synthesize the information needed for the solution of clinical problems; and to carry out those tasks that are the particular responsibility of the physician. Approaches should be described to improve students' acquisition of fundamental skills.*

*The Working Group on Personal Qualities, Values, and Attitudes is charged to describe desirable traits that students should develop during college preparation for medicine and during medical school, to assess how faculties might best select students who possess the capability to develop these traits, and to consider how faculties can foster the development of these traits in college and medical school.*

Again, to stimulate discussions among medical school and college faculties about their philosophies and approaches to medical education and college preparation for medicine, booklets in which the working group charges are discussed and some assumptions about each are posed, were circulated to medical schools, academic societies, and teaching hospitals in June. Additionally, medical school deans were invited to organize faculty and student discussions within their schools, using the "Charges" booklet as a guide in an effort that will parallel the national discussions among the project's three working groups. A total of 87 U.S. and Canadian medical schools have responded to this call and are initiating local efforts. In addition, 20 biomedical science professional organizations have indicated their intent to address these issues on a disciplinary basis nationwide. Over 7,500 booklets have been distributed since June.

Finally, 38 four-year colleges and universities, chosen to represent the schools from which medical school applicants and matriculants are drawn, have been invited to participate in this phase of the project.

### Regional Hearings

Another opportunity for communication among the panel and faculty, students, and others concerned with this project, including those in the practice of medicine, will be afforded between January and May of 1983, when hearings will be held in the AAMC's four geographic regions. Hearings will begin on January 27, at the University of California, San Francisco. Other hearings include the University of Texas, Houston, February 24; Northwestern University, Chicago, March 24; and the New York Academy of Medicine, May 5.

The final report of the project is planned to be presented at the Annual Meeting of the Association of American Medical Colleges in November, 1984. Interim reports will be disseminated for comment during the 1983-84 academic year.

For additional information contact Mary H. Littlemeyer, Project Coordinator,  
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