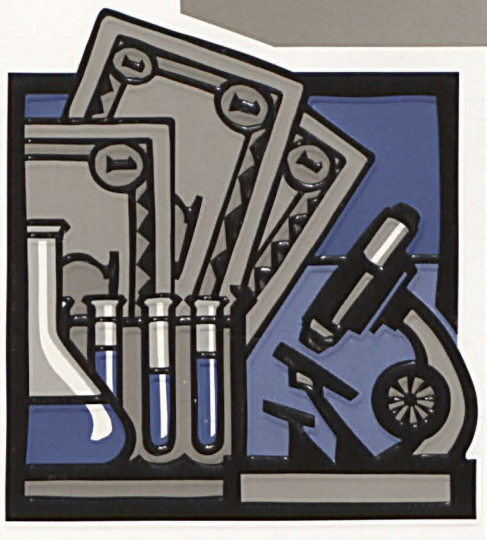




ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

1989-90
ANNUAL REPORT



*RISING
TO THE
CHALLENGE...*





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PRESIDENT'S MESSAGE



Three distinct events occurred in the life of the Association of American Medical Colleges this past year. Each represents a change from a comfortable present to a less certain future, but each offers a significant opportunity for progress and should enable even better representation of its members.

EXECUTIVE VICE PRESIDENT

In June John Sherman, Ph.D., retired as executive vice president of the AAMC, and I wish to pay tribute to a man who has played a fundamental role in the development of the Association. John has used his knowledge and understanding most effectively to further the cause of academic medicine and to support the biomedical research enterprise that is the foundation of medical education and improved patient care. One of his most significant contributions has been the development and nurturing of a number of broad-based coalitions in support of biomedical research. These include the Coalition for Health Funding and the Ad Hoc Group for Medical Research Funding, the latter uniting more than 150 organizations in support of appropriations for the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration.

Academic medicine is also indebted to John for his leadership on behalf of the use of animals in education and research. He was among the first to recognize the serious threat posed by animal "rights" activists, and his leadership laid the groundwork for the public campaign to combat that threat. John has been an effective spokesman for the Association on research policy, ethical standards in the conduct of research, conflict of interest, geriatrics, medical informatics,

and library and information resources.

It is with deep personal appreciation that I acknowledge John's contributions to the Association. Academic medicine is fortunate that we will continue to benefit from his powerful intellectual contributions in his capacity as a special consultant to me, focusing particularly on crucial problems of biomedical research funding.

As sad as we are at John Sherman's retirement, it is mitigated by the appointment of Edward J. Stemmler, M.D., to succeed him as executive vice president of the Association. Ed joins the AAMC staff after a distinguished career at the University of Pennsylvania, where he served as dean of the medical school and executive vice president of the medical center. Ed's long service on the Council of Deans, which culminated in his election as Chairman of the Association (1986-87), provides him with a sound understanding of the organization, its history, and its aspirations for the future. His considerable talents and broad experience as a medical educator and as an institutional and national leader will bolster AAMC's expertise in important arenas such as faculty practice, academic organization, humanism in medicine, and evaluation of students and residents.

GOVERNANCE AND STRUCTURE

In late 1988 AAMC Chairman D. Kay Clawson, M.D., asked the five most recent AAMC chairmen to serve as a Committee on Governance and Structure. Under the able leadership of John Colloton, the Committee was charged with recommending changes in the Association that would reflect the evolving views of its members about the future of the Association, the challenges

faced by academic medicine, and how the AAMC should be positioned to meet those challenges.

The Committee report recommended changes in the composition of both the Assembly and the Executive Council to increase the participation on those bodies by teaching hospitals and by academic organizations and to initiate participation by resident physicians through a new Organization of Resident Representatives. The nomination process for Association office has been revised to encourage the selection of the best-qualified men and women for leadership positions. The existence of the Association's professional development groups — Business Affairs, Educational Affairs, Faculty Practice, Institutional Planning, Public Affairs, and Student Affairs — will be formally recognized in the Association's corporate documents as a means of institutionalizing the very important contributions to the AAMC made by the key medical center personnel who make up the membership of these groups.

The report of the Committee and the consequent revisions in organizational structure will do much to shift the concept of the AAMC as a place where four disparate groups — deans, hospital directors, faculty, and physicians-in-training — are housed together in a sometimes uneasy alliance. It reinforces the view that the AAMC is the leader for and voice of all academic medicine by ensuring a more meaningful involvement in the AAMC by its entire membership. Education is the core and distinguishing mission of academic medical centers, but it is inextricably entwined with the delivery of high-quality medical care and the search for new knowledge through biomedical

research. The reorganization proposes a framework for a more flexible and responsive organization by recognizing this reality.

NEW HEADQUARTERS

Last February the Association broke ground for a new headquarters building to be located at 2450 N Street, NW. Construction will continue through this year and next, and the Association hopes to occupy its new offices at the end of 1991.

Funded by District of Columbia tax-exempt revenue bonds, this building will allow AAMC to consolidate its currently dispersed activities in a single location, will provide room for program expansion, including the move of the National Resident Matching Program to Washington, and will control future occupancy costs.

The new headquarters will serve as a visible symbol of the Association's representation and advocacy for academic medicine.

PROGRAMS

This year's annual meeting focuses on the biomedical research establishment including the travails of the past year. To be sure, while the "crisis in research funding" dominated the Association's activities, it was by no means our only effort. Each of our categorical divisions had an active agenda:

- *Biomedical research dealt with funding for biomedical research, use of fetal tissue in research, animal "rights", and misconduct and conflict of interest in research.*
- *Academic affairs considered medical school applicants (up by a healthy 6 percent from a year ago) and the selection process, design of the new MCAT, improvements in the MEDLOANS program, and engaged in an analysis of curriculum reform.*

- *Clinical services discussed the RBRVS, payment for graduate medical education, development of a data base for practice plans, and the impact of AIDS on residency choice.*

- *Communications produced a videotape on the attractiveness of a career in medicine, a resource notebook in support of the use of animals in research, and cosponsored a news briefing on animal research that enabled HHS Secretary Louis W. Sullivan to speak out on this important topic.*

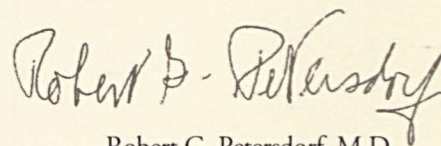
- *Minority affairs launched Project 3000 by 2000 which is designed to increase to 3000 the number of minority medical students in the class matriculating in the Year 2000.*

- *Institutional development completed a major project to reduce and make more coherent the information requested on behalf of the LCME and expanded our management education offerings.*

- *Graduate medical education revamped the National Resident Matching Program.*

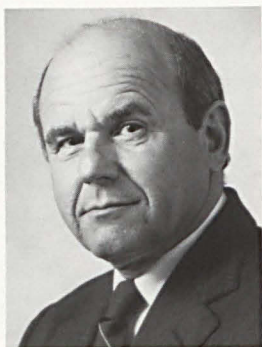
These are just "biopsies" of what the Association is doing, and there is much more; there always seems to be too much to do and too little time in which to do it.

As 1990 draws to a close, we can look at the remainder of the decade with an air of optimism and the promise that the Association is rising to the challenges it faces in representing the academic medicine community.



Robert G. Petersdorf, M.D.
AAMC President

CHAIRMAN'S REPORT



Ten years ago the Association of American Medical Colleges chose as the theme for its 91st annual meeting, "The New Biology and the Future of Medical Education." In his message to the Association, Chairman Charles B. Womer said, "This year we celebrate the importance and excitement of scientific discovery and the innovations in medical education which are being generated by new knowledge." Academic medical centers were justifiably proud of advances in clinical treatments that derived from knowledge revealed in basic science laboratories. There was a heady sense that biomedical research was offering real and substantial contributions to improving our nation's health and that we were poised for remarkable breakthroughs in areas such as genetics and neuroscience.

Now, a decade later, the biomedical community confronts "A Changing Reality for Biomedical Research" and puzzles over the forces that have eroded the productive optimism of 1980. This changing reality is particularly difficult for the community to understand because biomedical research has delivered so substantially on the exciting promises implicit at the start of the decade. The community feels confused, beleaguered, and deeply troubled. What has happened to the "Golden Age" during which so many of today's faculty came to professional maturity?

The development of the research-intensive university in this country is significantly rooted in the report of a commission constituted by President Franklin D. Roosevelt and chaired by Vannevar Bush. It established the foundation for an enduring and extraordinarily productive university-

government partnership by crafting a unique model in which the universities were designated as the primary venue of the federal effort in basic research. This achieved an insightful coupling of research training and practice. For almost half a century our research-intensive universities have thrived in a unique period in the history of science that offered unprecedented freedom of research in a climate of generous support. This was unquestionably instrumental in our nation's developing a scientific enterprise of unequalled quality and capacity.

However, forces are now in play that are closing this era and seem to be redefining the university-government partnership. The passing era has been one of rising expectations, and, for some, a growing sense of entitlement. We are now being educated in the stark reality that there is no natural law or categorical imperative for the support of science with public resources and that a federal presence in science is a matter of public policy with all the uncertainties that implies.

A number of issues have recently arisen or escalated in priority that are dominating public concern and making major claims on the federal budget. These include the environment, global climate change, the nation's deteriorating infrastructure, public education, drug and substance abuse, a growing underclass, the bailout of major financial institutions, and most recently the confrontation in the Persian Gulf. All insistently demand substantial incremental resources from an increasingly constrained federal budget.

Historically, the biomedical community, in presenting its case for federal

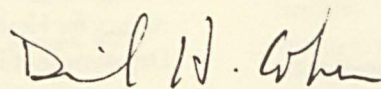
resources, has assumed an overriding public priority on investment in health. As we move into the 1990s, we must reevaluate the extent to which the traditional base of public support prevails as other issues capture increasing public concern and as negativity about uncontrolled health care costs grows. Is biomedical research viewed as part of the solution to rising health care costs or as part of the problem? Although opinion polls continue to indicate strong support for biomedical research, they may be misleading. What are the "revealed preferences" of the public? That is, given fixed and limited resources to be applied to an array of issues, how would the public choose to distribute its dollars?

In a relative sense biomedical research has been treated well, and this is the perception of the Congress. To a large extent the current feeling of crisis derives from the success of the enterprise. Available resources simply have not kept pace with the growth of scientific capability and opportunity. Our problem is one of managing a large, thriving, and enlarging enterprise in a situation of limited resources.

The AAMC and its members must recognize the changing reality and reposition themselves strategically in the debates for allocation of federal resources. We must clearly continue to press vigorously for resources, but in doing so we must demonstrate a realistic appreciation of current budgetary and public policy considerations by a willingness to prioritize, by constructively engaging discussion of a multi-year plan for the support of biomedical research, and by aligning our arguments as closely as possible to national needs as

perceived by the public and its elected representatives. I believe a case can be made effectively that an undesignated base of merit-reviewed support, coupled with more targeted funds, is, in fact, in the best national interest. The challenge is to forge a workable agreement with the Congress on the size of the base and its projected growth.

Finally, a disturbing and threatening development in the current situation has been early warning signs of an unravelling of the community's consensual approach to federal funding, an approach of empirically tested effectiveness that has been carefully and successfully crafted over the years. During the summer months the Association convened a series of discussion groups that included working scientists, academic leaders, and members of the AAMC governance and staff to address this concern. It is imperative to assume the maintenance of this unified approach; and perhaps more than ever before, this will require a real understanding by the broad community of the current fiscal climate, of public opinion, and of the management of research resources. Most importantly, it will demand unprecedented capacity for constructive compromise within our community.



David H. Cohen, Ph.D.
AAMC Chairman

GOVERNANCE
&
MEMBERSHIP

AAMC GOVERNANCE



Chairman of the Assembly
David H. Cohen, Ph.D.*
Northwestern University



Chairman-Elect of the Assembly
William T. Butler, M.D.*
Baylor College of Medicine



Past Chairman of the Assembly
D. Kay Clawson, M.D.*
University of Kansas
Medical Center
School of Medicine

President
Robert G. Petersdorf, M.D.*
Association of American
Medical Colleges

Distinguished Service Member
Ernst Knobil, Ph.D.*
University of Texas Medical School at
Houston

*Member of Executive Council

The Association is governed by an Executive Council whose members are elected from the Council of Deans (COD), the Council of Teaching Hospitals (COTH), the Council of Academic Societies (CAS), and the Organization of Student Representatives (OSR). The Association's legislative body is its Assembly, comprising all 126 members of the COD, 63 members of the COTH and the CAS, and 10 percent of the institutionally appointed members of the OSR.

Each year members and staff of the United States Congress and Executive Branch agencies and representatives of medical and health care organizations address the Administrative Boards and Executive Council on issues of interest and importance to academic medical centers. In 1990, AAMC leaders heard the following speakers:

Richard Averill
Vice Chairman
Health Systems International

Lowell Weicker
President
Research!America

Robert Derzon
Vice President
Lewin & Associates

J. Jarrett Clinton, M.D.
Acting Administrator
Agency for Health Care Policy and Research
Department of Health and Human Services

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School of Medicine and
Health Sciences, Washington, D.C.

Chairman-Elect

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Los Angeles
School of Medicine

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Northwestern University
Medical School, Chicago

George T. Bryan, M.D.*
University of Texas
Medical School at Galveston

William T. Butler, M.D.*
Baylor College of Medicine, Houston

David S. Greer, M.D.*
Brown University Program in
Medicine, Providence

Joseph E. Johnson, III, M.D.**
University of Michigan
Medical School, Ann Arbor

Leon E. Rosenberg, M.D.*
Yale University School of Medicine,
New Haven

Henry P. Russe, M.D.*
Rush Medical College of
Rush University, Chicago

Kenneth I. Shine, M.D.
University of California, Los Angeles
UCLA School of Medicine

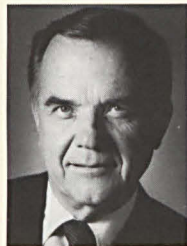
Robert H. Waldman, M.D.
University of Nebraska
College of Medicine, Omaha

Hibbard E. Williams, M.D.*
University of California, Davis,
School of Medicine

** Resigned July 1, 1990

***Resigned February 8, 1990

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Raymond G. Schultze, M.D.*
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Calvin Bland
St. Christopher's Hospital for
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Jose R. Coronado
Audie L. Murphy Memorial Veterans'
Hospital, San Antonio

Gary Gambuti *
St. Luke's-Roosevelt Hospital Center,
New York

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R. Edward Howell
Medical College of Georgia Hospital
and Clinics, Augusta

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University of California,
San Francisco, School of Medicine

Sister Sheila Lynne
Mercy Hospital and Medical Center,
Chicago

James J. Mongan, M.D.*
Truman Medical Center,
Kansas City, Missouri

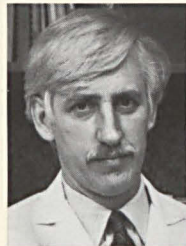
Robert H. Muilenburg
University of Washington Hospitals,
Seattle

Max Poll
Barnes Hospital, St. Louis

C. Edward Schwartz
University of Nebraska
College of Medicine, Omaha

Gail Warden
Henry Ford Health Care
Corporation, Detroit

COUNCIL OF ACADEMIC
SOCIETIES ADMINISTRATIVE
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Joe Dan Coulter, Ph.D.*
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College of Medicine, Iowa City

Chairman-Elect

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New Haven

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Cornell University Medical College,
New York

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School of Medicine at Huntsville

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Medical College of Virginia,
Richmond

Glenn C. Hamilton, M.D.
Wright State University
School of Medicine, Dayton

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West Virginia University
School of Medicine, Morgantown

Ernst R. Jaffé, M.D.*
Albert Einstein College of Medicine,
New York

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Medical Center, New York

Barbara J. McLaughlin, Ph.D.
University of Louisville
School of Medicine, Louisville

Vivian W. Pinn-Wiggins, M.D.
Howard University College of
Medicine, Washington, D.C.

Joel G. Sacks, M.D.
University of Cincinnati
College of Medicine, Cincinnati

ORGANIZATION OF STUDENT
REPRESENTATIVES
ADMINISTRATIVE BOARD



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Chairman

Caroline Reich*
Emory University
School of Medicine, Atlanta

Chairman-Elect

Lawrence Tsen*
University of Kansas Medical Center,
Kansas City
School of Medicine

Clayton Ballantine, M.D.
University of Louisville
School of Medicine, Louisville

Amy Davis
University of Missouri-Columbia
School of Medicine, Columbia

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Tom Lee
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Louisiana State University
School of Medicine at New Orleans

Lee Rosen
Baylor College of Medicine, Houston

THE COMMITTEE OF GOVERNANCE AND STRUCTURE

Since there has been no comprehensive examination of the Association's organization for more than 20 years, a special Committee on Governance and Structure was appointed in 1988 to consider the significant changes in the health care structure over the past two decades and to assess their effects on the Association and its constituents. The Committee has examined a variety of issues over the past two years and has made 12 recommendations that have been adopted by the Executive Council. These will be incorporated formally into the Association when the AAMC Assembly votes on by-law changes at the 1990 Annual Meeting. Changes will be made in the role and composition of the Assembly and the Executive Council, the membership of the Councils, the nomination process for the election of officers and the role of housestaff.

The Committee is composed of the immediate past chairs of the Association.

Chairman

John W. Colloton
University of Iowa Hospitals
& Clinics

Members

D. Kay Clawson, M.D.
University of Kansas Medical
Center School of Medicine

Robert M. Heysel, M.D.
The Johns Hopkins Health
System

Richard Janeway, M.D.
Bowman Gray School of
Medicine of Wake Forest
University

Edward J. Stemmler, M.D.
Association of American
Medical Colleges
(formerly, University of
Pennsylvania Medical Center)

Virginia V. Weldon, M.D.
Monsanto Company,
St. Louis, Mo.

Observers

William T. Butler, M.D.
Baylor College of Medicine

David H. Cohen, Ph.D.
Northwestern University

MEMBERSHIP

A non-profit Association founded in 1876, the AAMC includes in membership

- 126 U.S. medical schools and 16 accredited Canadian medical schools
- 405 teaching hospitals with substantial research and educational activities, including 70 Veterans' Administration medical centers
- 92 academic and professional societies representing approximately 72,000 faculty at member institutions
- Medical students at U.S. schools
- Over 700 individual members with demonstrated serious interest in medical education
- Faculty members and administrators of medical colleges and academic medical centers who represent their institutions in groups of similar professionals within the AAMC:

Group on Business Affairs

Group on Educational Affairs

Group on Faculty Practice

Group on Institutional

Planning

Group on Public Affairs

Group on Student Affairs

Governmental Relations

Representatives

(collaborative effort with the

Association of Academic

Health Centers)

SPECIAL RECOGNITION AWARDS

The Executive Council gave Special Recognition Awards this year to Congressmen William H. Natcher (D-KY) and Dan Rostenkowski (D-IL) for their strong leadership and support of the nation's biomedical and health care programs.

A Congressman since 1954, William H. Natcher has never missed a vote on the House floor—the all-time attendance record. He has served on the House Appropriations Committee since his second year in the House and served as chairman of that committee's highly influential Labor, Health and Human Services, Education and Related Agencies Subcommittee since 1979. The measure of Representative Natcher's support and leadership for biomedical research is demonstrated by the fact that, under his leadership, funding for the National Institutes of Health has increased from \$3.2 billion in 1979 to over \$7.5 billion in 1990.

David H. Cohen, Ph.D., AAMC chairman, presents the AAMC Special Recognition Award to Rep. William H. Natcher (D-KY) for his support of biomedical research.



Dan Rostenkowski was first elected to Congress in 1958, the youngest member of the 86th Congress. He became the first Chairman of the House Ways and Means Health Subcommittee in 1976 and since 1981 has served as Chairman of the House Ways and Means Committee. He has also chaired the Joint Committee on Taxation since 1981. Mr. Rostenkowski is one of the few current members of Congress who voted for the creation of the Medicare program and since that time has continued to work tirelessly to make it more comprehensive and more efficient.

Mr. Rostenkowski's commitment to the health of the nation's teaching hospitals and to the current health care system is evidenced by his ongoing support of appropriate funding of the indirect medical education adjustment.

Rep. Dan Rostenkowski (D-IL) accepts a Stueben crystal sculpture from Sister Sheila Lyne, president, Mercy Hospital and Medical Center, in recognition of his support for health care.



This year's Annual Report, "Rising to the Challenge," is not the typical year-end report. Instead of listing the Association's accomplishments and new programs of the past year, we have chosen to write a series of essays around a few of the key issues facing academic medicine in the final decade of this century. As you read it, we hope that you will find a renewed appreciation for the wide spectrum of challenges, choices, and opportunities that the health care community faces. It will take all the AAMC's intellect and energy as together we explore new ways to train physicians, provide health care, and conduct biomedical research in an increasingly pluralistic society.

THE STATE OF MEDICAL EDUCATION

The decade ahead holds the promise of substantial change for education leading to the doctor of medicine degree. The AAMC's 1984 Report on the General Professional Education of the Physician (GPEP), and the reports of other studies before it, recognized the need for change in medical education. These reports recommended a stronger focus on independent learning, less rote learning, and more problem-based thinking. They proposed various strategies designed to produce physicians skilled in compassionate and scientifically appropriate delivery of health care and equipped for a life of self-motivated continual learning.

These past recommendations have been more recently endorsed by reports such as that from the 1988 Josiah Macy, Jr., Foundation National Seminar on Medical Education. Spurred on by internal interest and these recent and past reports, medical schools have been reviewing the state of their programs. This enthusiasm for change was documented by the Robert Wood Johnson Foundation in its 1989 Louis Harris and Associates telephone survey of U.S. medical schools. In that survey, at least 96 percent of medical educators supported more rewards for teaching excellence, integration of the teaching of basic science and clinical medicine, improved methods for evaluating student skills, better opportunities for independent study, and increased emphasis on ambulatory educational experiences and general medical education. This year, as part of Assessing Change in Medical Education—The Road to Implementation (ACME-TRI), the Charles E. Culpeper Foundation-funded AAMC project, Association staff compiled a ten-year bibliography of educational innovations. This work also attests to the momentum for change building among the Association constituency.

There is indeed reason to be optimistic, but it is also not timely to be complacent. Surveys of graduating medical students still reveal large numbers of students decrying excessive lectures and noting inadequate outpatient experiences and insufficient self-directed study, and the decline in career selection toward primary care persists.

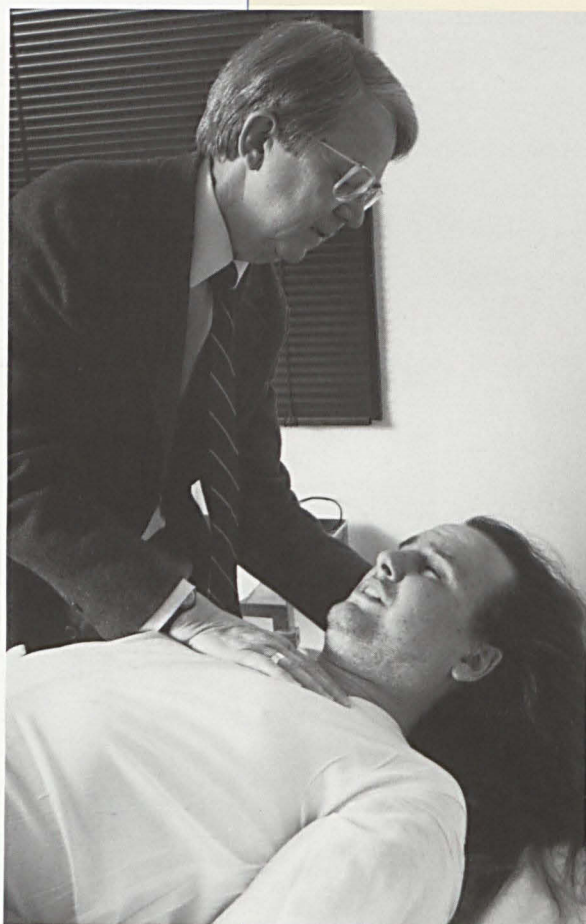
Ongoing AAMC research is clarifying the roles of the medical student selection process and of the educational program in career choices. Findings suggest the educational preparation of premedical students is related to career choice. Those students with a strong science focus in their premedical education appear more likely to choose procedure-oriented specialties. When that focus is lacking, students lean toward primary care and the non-procedure oriented specialties.

The AAMC has looked at the impact of the Medical College Admission Test (MCAT) on premedical education and on the selection process and

LOUIS J. KETTEL, M.D.
*Vice President
for Academic Affairs*



*Howard S. Barrows, M.D.,
associate dean for educational
affairs and chair of medical
education, trains a SIU simulated
patient (Danny Turner-Jones) in
the Professional Development
Laboratory at Southern Illinois
University School of Medicine.
SIU has developed and used
surrogate patients as a method of
assessing students' clinical
performances for nine years.*



has changed its focus. Beginning in 1991, the new MCAT will focus on complex thinking skills measured by interpretation of humanities concepts and on writing ability in addition to specific science content. The test changes are expected to influence premedical preparation substantially while providing admissions selection committees an appropriate predictor of performance in revised and innovative curricula.

Data from the AAMC graduating student questionnaire suggest that negative and positive forces during the educational program also influence student career choices. On the positive side are strong role models in the specialty. On the negative side are bad clerkship experiences. Informed of these findings, schools and specialty societies are instituting changes in the education program. These include adding required clerkship experiences in family medicine, restructuring the senior year offerings, and expanding community-based placements.

Many faculty are unprepared to institute innovations in education methods. The AAMC regularly holds workshops on techniques to implement evaluation strategies and to initiate and implement problem-based learning. Staff have visited a number of schools to assist in curricular evaluation and provide on-site assistance in the change process. Through its Student and Applicant Information Management System (SAIMS) database, the Association is providing baseline and follow-up data as a means to track the effects of these many changes.

As part of the ACME-TRI project, AAMC staff surveyed the deans to identify impediments to and facilitators of change. While early analysis of responses substantiated broad-based interest in reform, it also revealed the many obstacles and forces that obstruct modernization of medical education programs. The very nature of the health care system works against change. Its reimbursement practices and the highly competitive environment in which education occurs provide strong resistive forces to teaching in the ambulatory setting and distort the nature of patient care in the hospital setting. The need for faculty to provide the revenue for their salaries and, indeed, revenue for the educational institution distracts them from their primary teaching roles.

Appearing before the Council on Graduate Medical Education, AAMC staff encouraged the council to recommend

removing barriers to educational change created by the reimbursement system and avoiding their recurrence.

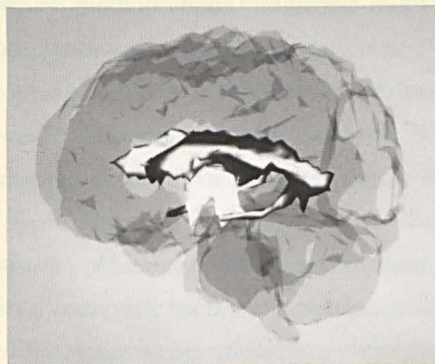
Foundations interested in medical education are doing much to stimulate change and overcome existing obstacles. These efforts include assisting schools to implement curriculum change, supporting efforts to integrate the teaching of basic and clinical sciences, developing models of health professions education institutions delivering care and teaching outside of major academic medical centers, and studying the forces that act on the education process. In meetings with these foundations, AAMC staff have outlined the disincentives to change and additional strategies needed to assist change.

The education community has begun to emphasize evaluation of the clinical performance of graduates. Objective Structured Clinical Examinations (OSCE) are now a part of the final evaluation process in at least 24 schools. The Association is working with the Clinical Skills Assessment Alliance to enhance the rapid development of standardized performance tests to be used by schools and licensing agencies.

To assist in accelerating and supporting change, a major goal of the ACME-TRI project is to identify successful strategies that overcome obstacles at the individual school level. These successful strategies will be published in the literature and further disseminated through workshops, seminars, and consultations to assure that the momentum for change continues.

The enthusiasm abounding in the medical education community, supported by the commitment of the AAMC and others, bodes well for the decade ahead. The promise for

change will be kept. Society does and should expect these changes in medical education and can look forward to well-prepared, caring physicians for years to come.



An interactive computer program developed at Tufts University School of Medicine enables students to study three-dimensional images of the brain and central nervous system from a variety of vantage points.



Participants in the AAMC Rural Health Symposium sponsored by the Kellogg Foundation included keynote speaker Sam M. Cordes, Ph.D., head, Department of Agricultural Economics, University of Nebraska, Tom M. Johnson, M.D., associate dean of the Michigan State University College of Human Medicine and chairman of the AAMC Steering Committee on Rural Health, and Thomas A. Bruce, M.D., program director, Kellogg Foundation.

JAMES D. BENTLEY, PH.D.
*Vice President for
 Clinical Services*

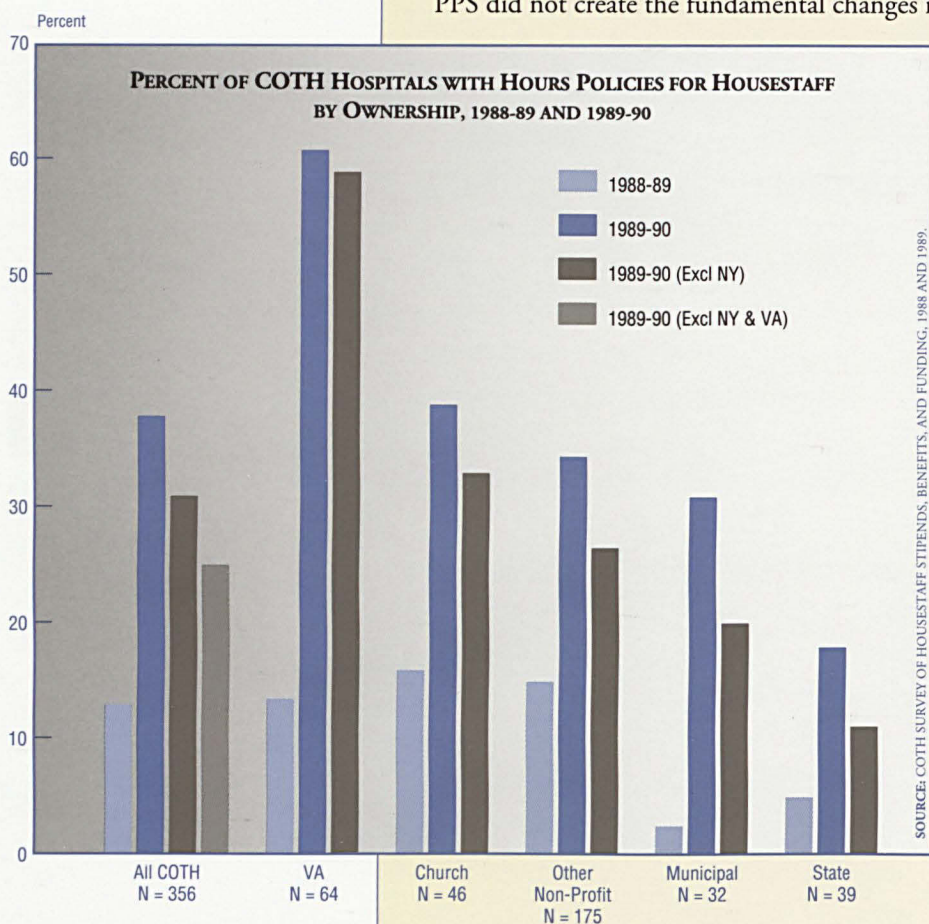
DEVELOPING THE DECISION SCIENCES

As the 1990s begin, many people are looking back at the 1980s to identify the sources of fundamental changes reshaping our society. In the organization and financing of health care services, Medicare's prospective payment system (PPS) is often seen as one significant source of change. PPS did reform the Health Care Financing Administration's role from a relatively passive payer to an active price setter; focused attention on previously arcane issues like the financing of capital and of graduate medical education; shifted financial risk to hospitals, allowing them to make a profit or suffer a loss; and encouraged changes in patterns of admissions and lengths of stay.

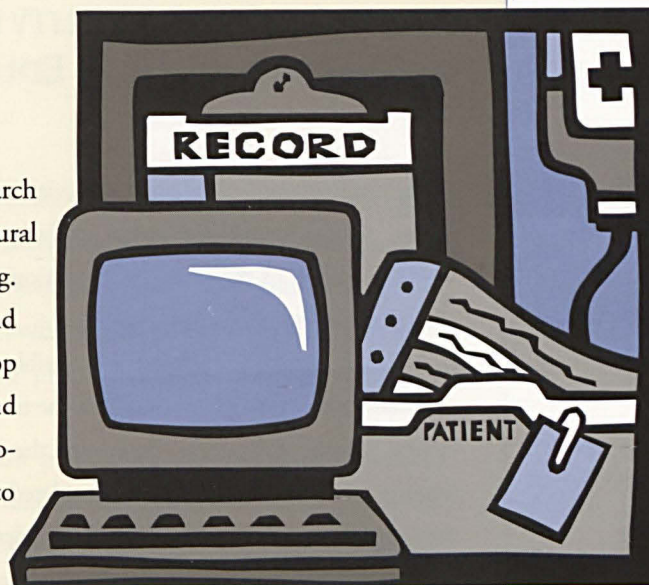
In this last area, however, payment changes receive more credit than they deserve. The trend to shorter lengths of stay preceded PPS. New anesthetics, improved surgical techniques, and innovative diagnostic services available in the ambulatory setting already were changing admission patterns. The economics of prospective payment may have reinforced changes in practice patterns already under way, but the economics of PPS did not create the fundamental changes in medical practice.

The peer review organizations (PROs) included in the PPS legislation signaled a more significant change in medical practice and clinical education. To assure that the economic incentives of prospective payment did not undermine the quality of care provided Medicare beneficiaries, the PROs were established to review and evaluate decision-making in clinical practice.

Admittedly, the PROs are still embryonic organizations often relying upon elementary methodologies to assess clinical practice; they may not survive as currently structured. Nevertheless, the interest in clinical decision-making that led to the PROs has grown along many fronts. Clinical effectiveness, outcomes research, and appropriateness have gone from the lexicons of the few to the interest of many. The



new Agency for Health Care Policy and Research will expand federal initiatives, both intramural and extramural, in clinical decision-making. New research centers in teaching hospitals and medical schools are being formed to develop analytical methodologies, analyze data, and create guidelines for clinical practice. The biological and behavioral sciences fundamental to medical practice are being joined by the "decision sciences".



The decision sciences of medical practice are in their infancy. Although E. A. Codman, M.D., made the basic argument favoring the decision sciences over seventy years ago, only in the past five years has the literature included a continuous and growing series of studies and reports. Clinical societies, medical associations, and special purpose consortia now actively develop projects to describe, evaluate, and guide clinical decision-making. Soon, these efforts will join with developments in artificial intelligence and medical informatics to extend dramatically the resources available to the physician facing a diagnostic or treatment decision.

In the decade ahead, the decision sciences will have a dramatic impact on hospital medical staffs and on clinical teaching in both inpatient and ambulatory settings. Medical staffs will need to be organized and supported to move far beyond their current emphases on credentialing and continuing education. They will have to develop the resources, both in information and personnel, to evaluate and adopt guidelines for clinical practice. Information systems in teaching hospitals and practice plans will have to move beyond billing and order entry to monitoring compliance with practice guidelines and to documenting justifiable variations from the anticipated norm. Educational methodologies and programs will have to be examined and revised to ensure that students and residents are prepared to learn and function independently in a clinical setting of practice guidelines and policies.

The demands on physicians and clinical organizations will be enormous. Incorporating the decision sciences involves the simultaneous creation of new disciplines and the modification of both existing organizations and programs to make effective use of them. As a result, academic medical centers will be challenged to develop intellectually supportive environments, standards of scholarship, and models of practice organizations that provide paradigms for the broader society.



*Gail R. Wilensky, Ph.D.,
administrator, Health Care
Financing Administration,
addresses the COH
Spring Meeting.*

AUGUST G. SWANSON, M.D.
 Vice President for
 Graduate Medical Education

ACCEPTING RESPONSIBILITY FOR THE QUALITY OF GRADUATE MEDICAL EDUCATION

Graduate medical education is a vital concern of the AAMC membership. Yet standard-setting for and evaluation of the quality of that education falls entirely outside the purview of the member institutions. For a variety of reasons, this decade may see a change in this anomalous situation.

Medical schools, which are responsible for preparing medical students for their post-graduate residencies, are grounded in the traditions of institutions of higher education. Each faculty has the authority to determine the curriculum and set the evaluation standards for judging whether students have completed the course of instruction satisfactorily. When they award degrees, medical school faculties exercise an authority granted to them by state charters. They are expected to exercise this authority responsibly, to grant degrees only to those who have demonstrated the knowledge and skills required to become competent medical doctors.

Teaching hospitals and medical schools play no analogous role in the awarding of specialty certificates. Teaching hospitals and the residency programs they sponsor evolved from apprenticeships in medical and surgical specialty practices. As national standards of education and evaluation for residents developed, the authority and responsibility for standard setting and evaluation were vested outside the hospital and university. Today, programs must comply with educational requirements set forth by the residency review committees of the respective specialties. Residents are examined by autonomous, self-designated national certifying boards. Thus, the institution is responsible for neither curriculum requirements nor the ultimate evaluation of the performance of its residents. This external control has

resulted in variable degrees of dedication to excellence in resident education and has permitted passivity among some teaching hospitals about their educational responsibilities. However, in the future, institutions are likely to be expected to assume much greater responsibility for the quality of the programs they sponsor.

In 1965, a committee chaired by Lowell T. Coggeshall, M.D., expressed the view that medical schools and their parent universities should become responsible for the education of residents. This view was endorsed strongly in 1969 in a report of the first conference of the AAMC's Council of Academic Societies, entitled *The Role of the University in Graduate*



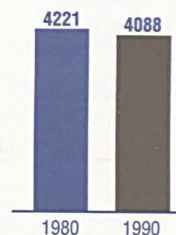
Medical Education. A statement on graduate medical education endorsed in 1971 by the Association's Assembly stated in part, "... the Association urges the faculties of academic medical centers to develop, in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education."

Widespread endorsement notwithstanding, the proposition that institutions should be responsible for the quality of education of their residency programs was not well accepted, especially by certifying boards and the residency review committees. Both had focused (and continue to focus) on a system in which programs are accredited, not institutions, thus perpetuating external control.

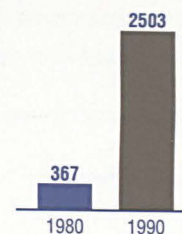
In 1980, a revision of the General Requirements section of *The Essentials of Accredited Residencies* set forth explicit institutional requirements, but no method was developed to determine whether institutions were complying with the requirements. Now, a further revision of the General Requirements has been approved by the Accreditation Council for Graduate Medical Education (ACGME) and is in the process of being ratified by the sponsoring organizations. This time the ACGME intends to implement a process to ensure that teaching hospitals comply with the general requirements.

Recent actions by some certifying boards also will place greater responsibility on teaching hospitals. There has been resistance to the proliferation of subspecialty certificates by some specialty societies. In response, several certifying boards have asked residency review committees for their specialties to accredit training programs in one or more of their subspecialties for which neither examinations nor certification will be provided by the boards. The responsibility for certification of physicians who complete these subspecialty training programs will be lodged with the programs and their sponsoring institutions. Sponsors of these subspecialty training programs will have to develop *internal* methods of evaluation to ensure that they certify only those who merit it. Attaining compliance with the General Requirements will facilitate the establishment of evaluation methods.

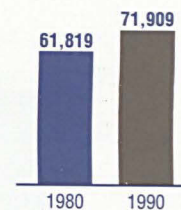
These changes challenge members of the AAMC to work together during this decade to improve the institutional base for graduate medical education. It is unlikely the institutional form that evolves will be exactly as envisioned by the Coggeshall Committee, the CAS, or the AAMC Assembly. Still, affording more authority and responsibility to medical schools and teaching hospitals will enhance the quality of the essential second phase of the education of physicians and surgeons.



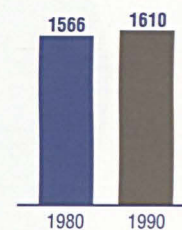
NUMBER OF ACCREDITED PRIMARY SPECIALTY RESIDENCY PROGRAMS



NUMBER OF ACCREDITED SUBSPECIALTY RESIDENCY PROGRAMS



NUMBER OF RESIDENTS IN ALL ACCREDITED PROGRAMS



NUMBER OF INSTITUTIONAL & AGENCY SPONSORS

JOSEPH A. KEYES, JR.
 Vice President for
 Institutional Planning and
 Development

ACCREDITATION: REFLECTIONS ON ITS ROLE AND PURPOSE

At its June 1990 meeting the AAMC Executive Council considered a first "exposure draft" of amendments to *Functions and Structure of a Medical School*, the statement of the accreditation standards of the Liaison Committee on Medical Education (LCME). This process makes it timely to reflect on why the Association is involved in accreditation and what is reasonable to expect from that activity.

The mission of the AAMC from its inception has been to advance the quality of medical education in this country. One device to accomplish this purpose was limiting Association membership to medical schools that pledged to, and in practice did, meet specified minimum standards. Over time, a formal process was developed both to set such standards and to evaluate institutional compliance to them. A parallel system of evaluations conducted by the American Medical Association (AMA) was first totally separate, then in 1942, linked through a "liaison committee", and finally merged into a single system. Today, the LCME enjoys a certain autonomy from the control of its two founders. The LCME decisions on the status of individual programs are final, no longer subject to approval by the AAMC or the AMA. The founding organizations continue to underwrite the cost of the process, with substantial contributions made by members of the academic medicine community who serve as volunteer site visitors and committee members. The two parent bodies each appoint six professional members and a student nonvoting participant to the LCME while the Committee itself appoints two public members. The Canadian Association of Medical Colleges appoints a member and the Secretary of Health and Human Services appoints a nonvoting participant. The Executive Council of the AAMC and the Council on

Medical Education of the AMA retain the authority to give final approval to the standards.

In fulfilling their responsibilities to set standards, the LCME and its parents must avoid the twin hazards of their own reformist aspirations and pressures of external expectations. Many interest groups look to the LCME as a preferred vehicle to advance their views on ways to improve the performance of physicians or to change medical education. Characteristically, reformers regard their only task as one of setting forth an argument that the LCME might regard as persuasive. They expect the LCME to reduce their recommendations to "law" and then to bring all schools into compliance.



A better conception of the LCME recognizes that its standards reflect the shared judgment of both the practicing community and the academic community as to the minimum requisites for an acceptable program of medical education: adequacy of faculty and students, facilities, leadership, and pedagogic approach. By this conception, a program not in compliance is one that does not comport with the reasonable expectations of its peers. Thus, appropriately, a desirable program attribute will have gained wide, nearly universal, acceptance as being necessary prior to being adopted as an accreditation "standard."

Ideally, the process of accreditation should not be an impediment to educational reform; however a change in standards generally can be expected to follow rather than precede wide acceptance in the community. Admittedly, overcoming the inertia of entrenched practices is a significant burden for advocates of "a better mouse trap," but the LCME is far better suited to be the conservator of traditional values than the engine of progress.

It is as the articulator of the core values shared by virtually the entire community that an accrediting body serves its role. In a fundamental sense, the standards set by the LCME and its actions in upholding those standards define the meaning of the doctor of medicine degree. Thus, while its underlying values should persist beyond fads and fashions, its standards must change as the reality of medical knowledge or medical practice evolves. Consequently, while not an effective change agent, the LCME draws enormous strength from its capacity to develop and express the consensus of the profession.

Accreditation is useful because self-examination and peer review serve a need recognized by both the profession and its academic colleagues. The effectiveness of accreditation has permitted others to use accreditation decision-making to accomplish other objectives such as establishing prerequisites for federal funding or state licensure of medical school graduates. However, these uses always should be recognized as secondary and derivative. If they were to become primary, the process itself would be distracted from its initial and core function and eventually distorted in ways destructive of its underlying purpose.

The LCME has brought forth several proposals for modifying its standards. The next year will see them subjected to the trial of consensus development. Both the profession and academe should celebrate this occasion for the testimony it gives to the vitality and validity of accreditation in medicine.

MANAGEMENT EDUCATION PROGRAMS

Throughout the year the AAMC offers a variety of workshops and seminars to help academic medical center managers anticipate future needs and develop and implement innovative strategies.

- *AAMC/VA Seminar on Clinical Affiliations*
- *Evaluating and Promoting Medical Students*
- *Executive Development Seminar for Association Deans and Department Chairs*
- *Executive Development Seminar for Deans*
- *Faculty Affairs Professional Development Conference*
- *Information Technology in the Academic Medical Center*
- *Introducing a Problem-Based Learning Curriculum*
- *The VA Medical School Relationship: Maximizing Opportunities*
- *Women in Medicine Professional Development Conference*

EQUITY AND ACCESS

HERBERT W. NICKENS, M.D.

*Vice President
for Minority Health,
Disease Prevention/
Health Promotion*

At the beginning of this century, W.E.B. DuBois stated in the *Souls of Black Folk* that the “problem of the twentieth century is the problem of the color line”. Now, near the end of the twentieth century, the *Washington Post* has published an op-ed piece entitled “Our Racial Problems Are Very Patient.” In between these two events a great deal has occurred. Yet, as the *Post* article suggests, not nearly enough progress has been made. However, we seem to be entering one of those periods in our history when the problems of America’s minority peoples are again the object of national concern, and, perhaps, activism.

This is also a period in history when the world’s balance of power is shifting and America is uncertain of her status. Commentators predict that in the future national power and

prestige will flow largely from economic rather than military sources. People will become the most important national resource.

Yet in the year 2020, about 40 percent of America’s school-age population will be minorities, many of whom suffer severe and long-tolerated educational disadvantages. How our nation responds to this problem raises not only philosophical questions about our national morality—the traditional framework in which these issues have been raised—but also pragmatic questions about how well we are training the next generation of workers.

In parallel with anxiety over national economic competitiveness, is the increasing acceptance that our health care system, the world’s most expensive, is highly uneven both with regard to access and to the outcomes it delivers. Examples abound:

- At least two-thirds of our more than 31 million uninsured people live in families in which the principal breadwinner is employed
- The infant mortality of white Americans taken alone would rank 14th in the world
- The life expectancy of Black men in Harlem is less than that of men in Bangladesh.

INFANT MOTALITY RATES IN SELECTED COUNTRIES, 1986

Japan	5.2
Finland/Sweden	5.9
Switzerland	6.8
Hong Kong	7.7
Netherlands	7.8
Canada	7.9
France/Norway	8.0
Denmark	8.2
Federal Republic of Germany/Spain	8.5
Ireland	8.7
Australia/Scotland	8.9
United States (White)	8.9
German Democratic Republic	9.2
Singapore	9.3
England and Wales	9.6
Italy	9.8
Northern Ireland	10.2
Austria	10.3
United States (all races)	10.4
New Zealand/Israel	11.4
Greece	12.3
Czechoslovakia	13.4
Cuba	13.6
Trinidad/Tobago/Puerto Rico	13.7
Bulgaria	14.7
Kuwait	15.7
Portugal	15.9
Belgium	16.1
Poland	17.5
Costa Rica	17.8
United States (Black)	18.0
Hungary/Chile	19.1
U.S.S.R.	25.1
Romania	25.6

SOURCE:
Health United States 1989. U.S. Dept. of Health and Human Services

The AAMC's renewed commitment to minority issues occurs at a time of particular ferment regarding the well-being of the nation in general, and of a growing recognition of the centrality of minority people in the nation's future, in particular. Twenty years ago the Association made a commitment to equal opportunity in medicine by creating the AAMC Section on Minority Affairs. A year later an AAMC task force set as a short-term objective that "...U.S. medical schools increase the representation of minorities in the M.D. degree programs from 2.8 percent to 12 percent by 1975-76." That goal, based solely on population data for Blacks, the only minority for which reliable data were available at that time, has never been reached.

The Association seeks to re-invigorate the efforts to meet that original task force goal. The principle underlying that goal is that the representation of a minority group in medicine should at least equal the proportion of that group in the population (population parity). This goal is amply justified on grounds of equity alone, but there are other reasons why it is important:

- There is evidence that minority practitioners serve within their practices a higher representation of minority patients, and one could speculate that they are also likely to be more culturally sensitive to minority patients.
- Increasingly medical careers are becoming more diversified with physicians serving as administrators in the academic medical enterprise and in public health, as researchers, and as policymakers in government. It is important that these roles also have the benefit of the diverse world views and values represented by minority physicians.

Despite the turbulence of the past decade, academic medicine retains a special status in our educational and health care systems and in our communities. Providing leadership in solving the problem of the color line offers a chance to "do good and to do right." Our problems may be very patient, but the world is not.



NEW SEMINAR

UNDERREPRESENTED MINORITY FACULTY CAREER DEVELOPMENT SEMINAR

Sessions to help faculty understand barriers to, and develop successful strategies for, achieving promotion and tenure.

- *Understanding Criteria for Promotion and Tenure*
- *Grantsmanship*
- *Conflict Management*
- *Writing for Journals*
- *Development of Research Plans*
- *The Role of Mentors*
- *Development of a Career Plan*
- *Project Management*
- *Organization and Financing of Academic Medicine*
- *Time Management*
- *Special Challenges Facing Minority Faculty*

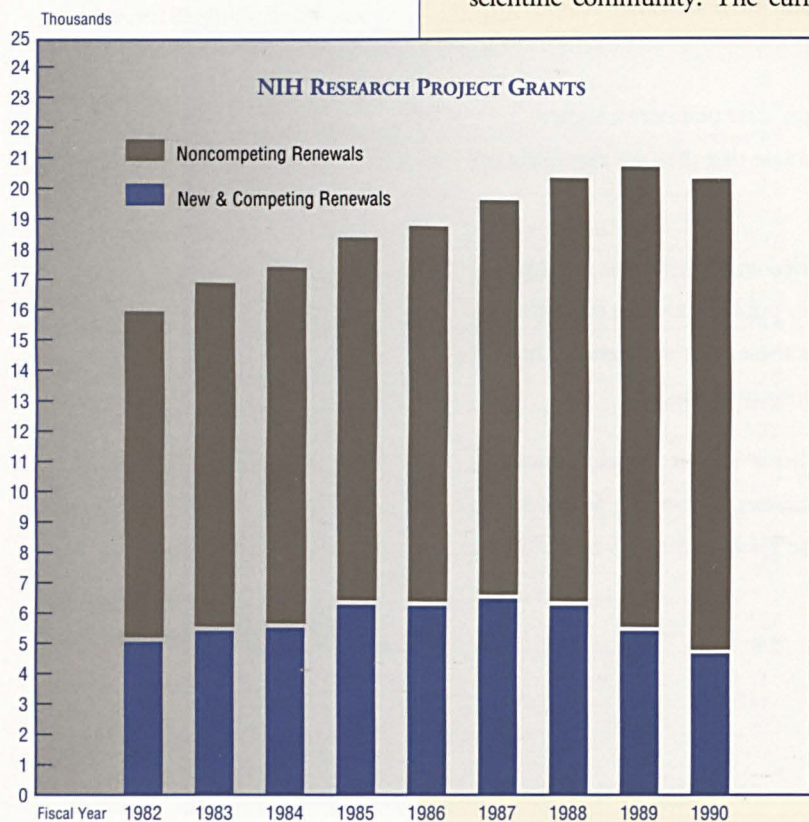
THOMAS E. MALONE, PH.D
 Vice President for
 Biomedical Research

BIOMEDICAL RESEARCH IN THE TWENTY-FIRST CENTURY: CHALLENGES FOR THE AAMC

The U.S. biomedical research enterprise has achieved remarkable success during the last half of the twentieth century. With the explosive growth of molecular biology accompanied by new and powerful technologies and the impact of the increasing integration of many biological disciplines, unparalleled scientific opportunities will usher in the twenty-first century. But continued success will require serious examination of those imperatives that have driven and sustained the nation's biomedical research system. These forces, surprisingly effective until now, have represented a multifaceted policy-making apparatus that has been selectively responsive to economic, social, and special interest pressures. The object of these pressures has been the Congress, which considers in its process a myriad of competing demands and makes decisions that determine the ebb and flow of resources available for biomedical research.

A fundamental imperfection in this decision-making process, as recognized in the 1986 report of the AAMC's Ad Hoc Committee on Federal Research Policy, is the absence of a mechanism to achieve a general consensus of the scientific community on key policy issues and priorities for biomedical research. This flaw results in a system that reacts to prevailing influences, often fostering disagreement and competition for available resources within the scientific community. The current "crisis" in biomedical research is an example of this

situation. The precipitous decline in the number of competing awards for investigator-initiated research, due in part to a decision to lengthen the grant period, has created a state of severe competition. There is competition not only for new and competing renewal projects but also between these and other support modalities such as center grants, program projects, and general research support programs. New initiatives are coming under special scrutiny. Despite the prospect that the Human Genome Initiative may set the research agenda for the 21st century, peer competition has been an important factor in funding decisions that will slow its pace of growth. A similar fate may await the initiatives planned for the "Decade of the Brain." The deterioration of the infrastructure for biomedical research is a reflection of long-term neglect of a problem that might well have been avoided by strong and general consensus in the scientific community for the support of construction and facilities in the legislative process.



The current funding crisis has many tangential consequences that also must be considered at the highest policy-making levels. For example, as many fear, the temporal funding "crisis", and the professions reaction to it, may be driving bright young students from research and teaching careers. This threat to the next generation of scientists is exacerbated by the crisis in science education, the already serious underrepresentation of minorities in research, and the shortfall in scientists and engineers expected early in the next century. To these must be added the legal, social, philosophical, and ethical issues that will accompany an era when genetic intervention in humans increasingly will be possible. It is unlikely that the old policy-making apparatus that has brought science this far is adequate to meet these challenges.

The question is how do we achieve consensus policies on these issues among scientists who are by definition independent thinkers and who must preserve that precious element of creativity? Moreover, what is the mechanism to achieve such consensus and under what auspices? What is certain is that as we enter a period of immense opportunity in biomedical research, scientists as individuals and as a community must re-examine the present policy-making structure. We must begin by assessing the appropriateness of policies and programs that were developed during a period of economic growth when public governance of science was minimal. We must work nationally and locally to engender public enthusiasm and understanding of the value of research. We must help find solutions to the crisis in education and the problem of the future supply of researchers and faculty. We must help modify the medical curriculum to include the fruits of molecular biology and of new technologies. We must take time from the laboratory to learn better the complexities of the funding process and to develop a common voice for priorities in a period of severe fiscal constraints. We must develop new justifications for increased funding based upon documented past and future returns of biomedical research to society. We must develop options that will allow Congress to deal with conflicting demands across agencies. We must even examine whether the most efficient use is being made of funds appropriated for research. Above all, scientists must work to replace the fragmented science policy apparatus of the past with one that can provide informed and sustained advice to the Executive Branch of government and the Congress. These are but a few of the challenges facing the AAMC and its constituency as we approach the 21st century.



Michael J. Jackson, Ph.D., chair, AAMC Ad Hoc Committee on Misconduct and Conflict of Interest, leads the first AAMC/NIH regional workshop.

ELIZABETH M. MARTIN
*Vice President
 for Communications*

PUBLIC UNDERSTANDING OF SCIENCE: WHOSE JOB?

The greatest achievements in medicine have happened in our lifetime. Yet the public has a surprising degree of misunderstanding about the part that science has played in making these achievements possible. Few Americans know their scientific facts and only 12 percent understand scientific processes. We have developed effective cancer treatments and organ transplantation, but an increasingly suspicious, frightened and ill-informed public threatens further advances. This is demonstrated in a myriad of ways—through the controversies over development of gene therapies and the increase in animal “rights” activities.

What is the scientific community’s role in combatting this drift toward anti-intellectualism? Can it be effective players in the education system and through the media to increase the public’s interest, understanding, and support for science?

Seven years ago the National Commission on Excellence in Education released a report on the state of American education. Titled “A Nation at Risk: The Imperative for American Educational Reform,” the report was concerned about the “rising tide of educational mediocrity” and cautioned that unless it strengthens high school graduation requirements, teacher preparation, and “the new basics,” America will not be able to “retain its pre-eminence in commerce, industry, science, and technological innovation.” It galvanized the American public like nothing since Sputnik.

Since that time, concern has not diminished. Questions are still being raised about the way our educational system is organized and the roles of business, industry, and academe in supporting quality education.

It starts in the early school years. Too often the science that is taught in our schools has little to do with what science is really about. Students report that the subject is boring. They leave school with at best no interest and little understanding of the role of science in everyday life and at worst a dislike or fear of science that makes future communication efforts ineffective.

This has been dramatically illustrated in a series of surveys by Jon D. Miller, Ph.D., director, Public Opinion Laboratory, Northern Illinois University. Five hundred years after Copernicus discovered that the earth revolved around the sun, Miller’s research group disclosed that one-quarter of adults polled believed otherwise.

Millions also believed that astrology is a science. This reflects the public’s misunderstanding of science and the failure of the education process.



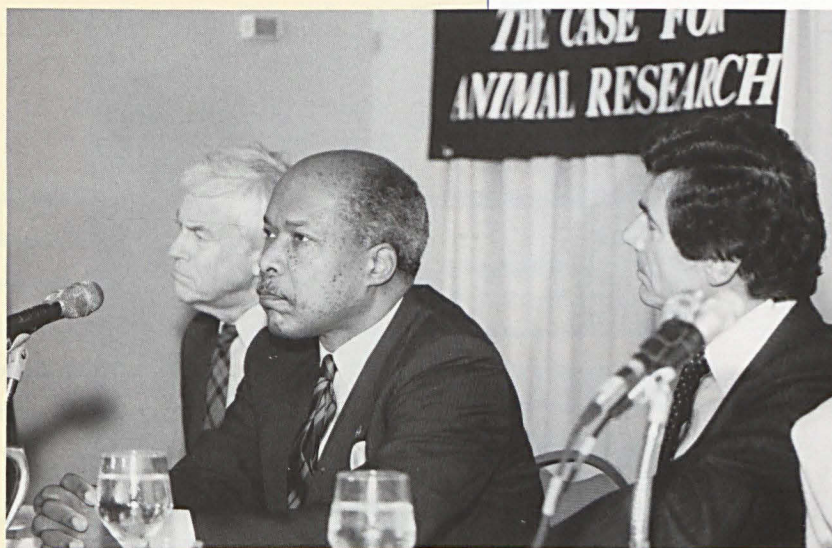
EDUCATIONAL PARTNERSHIPS

In the best of all possible worlds, our education system would do the job and scientific illiteracy, like smallpox, would be a thing of the past. However, it is naive to relegate responsibility for informing the public about science entirely to the schools. Whether by supporting the existing system, fostering innovative but incremental change, or working for major structural changes in the system, businesses, other private sector institutions, and AAMC constituents are lending a hand to education in their communities. Initial efforts include supplying schools with special demonstrations and guest speakers; establishing awards programs; donating materials and equipment; providing use of facilities and conducting tours. More ambitious programs aimed at helping teachers do their jobs better and enriching students' experiences include a lecture series on innovations in medical research and summer programs in medical school laboratories.

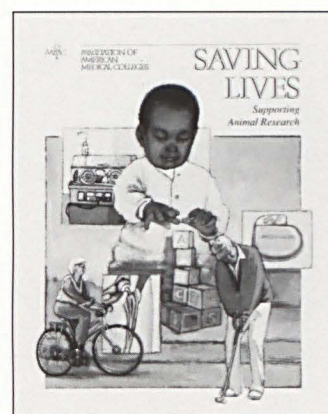
MEDIA PARTNERSHIP

Once the school years are over, one way to improve scientific literacy is use of the mass media to build understanding of science and of the issues that affect the formulation of science policy. Although scientists tend to disparage mass media coverage of science, the public use the media to monitor what is going on in science, including developments in their own fields. In one study, 60 percent of medical school faculty members reported that they sometimes learned of new medical developments through the mass media. Although the scientific culture long has discouraged scientists from speaking out, universities, scientific societies, and associations now have come to consider these activities important in the fight for public opinion and congressional support. The communications professionals at AAMC institutions identify, develop, and implement science communication programs and provide that important link between the world of science and the media.

If we are serious about improving scientific literacy, then physicians, scientists, and those who support them must take on more of the challenge. Ordinary people cannot understand science unless scientists make it understandable. As Isaac Asimov has written, "Attempting to educate the public in science is difficult....The stakes, however, are very high, and we have no choice but to try...and to remain undaunted by defeat....What is the alternative? To leave the world to the *National Enquirer*, the astrologists, and the creationists? Never!"



L. Thompson Bowles, M.D., Ph.D., executive dean, George Washington University School of Medicine and Health Sciences, Louis W. Sullivan, M.D., secretary, U.S. Department of Health and Human Services, and David Birney, patient advocate and actor, answer questions at the AAMC news briefing on use of animals in research.



The AAMC developed Saving Lives, a resource notebook, to help institutions take creative, positive steps to support and promote the continued humane, responsible use of animals in biomedical research and education.

OFFICE OF GOVERNMENTAL RELATIONS

The Office of Governmental Relations is the focal point for the Association's interactions with the federal government on all legislative matters. The office monitors federal legislative initiatives related to medical education, research, and hospital and physician payment and other policy issues; provides background on legislative activity for AAMC constituents and staff; and coordinates Association communications with the Congress and Executive Branch agencies. The Association mounted four major advocacy efforts during 1990.

BIOMEDICAL RESEARCH FUNDING

Both individually and through its leadership of the Ad Hoc Group for Medical Research Funding, the AAMC continued to make the case for an enhanced federal investment in the biomedical and behavioral research conducted and supported by the National Institutes of Health (NIH) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

Recognizing the increasing role of the House and Senate Budget Committees in the allocation of federal funds, the AAMC, individually and through membership in the Coalition for Health Funding, advocated an increase in budget function 550, the component of the federal budget that covers discretionary health programs, including the Public Health Service and Medicaid. These efforts were rewarded by the decision of the House Budget Committee to provide an additional \$750 million above the president's request for the NIH in fiscal year 1991.

The AAMC also led efforts by medical schools and research and professional organizations to urge the Congress to reverse the administration's proposal to reduce funding for the Biomedical Research Support Grant (BRSG) program by over 70 percent. These efforts emphasized the importance of BRSG funds in recruiting new faculty, supporting established researchers experiencing gaps in funding, and supporting pilot studies of innovative research ideas.

MEDICARE PAYMENTS

In its FY 1991 budget, the administration proposed significant reductions in Medicare payments to teaching hospitals. Of the \$3.4 billion in proposed reductions in FY 1991 Medicare expenditures for hospital inpatient services, over \$1.2 billion—nearly 36 percent—was to be achieved by cutting the indirect medical education (IME) adjustment and the direct graduate medical education payments to teaching hospitals.

In its interactions with the budget committees and the House Ways and Means and Senate Finance committees, the AAMC stressed its analysis of financial data for 1986 through

1989 provided by 46 Council of Teaching Hospital-member medical center hospitals. Based on 1989 data, the administration's planned reduction of the IME adjustment from 7.7 percent to 4.05 percent would have resulted in a decrease in the average Prospective Payment System (PPS) margin from plus 4.5 percent to minus 7.8 percent for these hospitals.

The Association opposed the administration's proposal to establish a per resident payment amount based on the FY 1987 national average of residents' salaries, with primary care residents weighted at 180 percent of the per resident amount, non-primary care residents weighted at 140 percent, and non-primary care residents beyond the initial residency period weighted at 100 percent. Not only does the administration's proposal reduce payments, the Association noted, it also assumes a relationship between Medicare payments to hospitals and medical students' selection of residency choices that does not exist.



VETERANS' ADMINISTRATION (VA) MEDICAL CARE AND RESEARCH

The continued shortfall in funding for the Veterans' Health Service and Research Administration threatens the scope and quality of the VA health care system. Responding to this challenge, the Association, in collaboration with the American Federation for Clinical Research and the Association of Professors of Medicine, spearheaded a coalition to increase federal support for VA health care. The Friends of VA Medical Care and Health Research recommended an 18.4 percent increase in the medical care budget to maintain current levels and standards of care and to provide for small measures of growth, including an expanded extended-care program, increased use of outpatient clinics, new equipment purchases, and a revised physician compensation formula. For health research, the Friends of VA advocated a 26 percent increase, which includes special research initiatives in such areas as AIDS, mental illness, nerve regeneration, and health services.

HEALTH MANPOWER

In 1990, the Association undertook a number of activities related to increasing support for health professions training. The AAMC urged Congress to provide an additional \$120 million to continue existing health manpower programs that the administration had proposed to eliminate, including primary care residency training in general internal medicine, general pediatrics, family medicine and preventive medicine; departments of family medicine; geriatric education centers and faculty development; area and border health

education centers; model education project grants; and the Council on Graduate Medical Education.

The AAMC supported increased funding proposed by the administration for National Health Service Corps recruitment programs (scholarships and loans) and actively supported the reauthorization of the NHSC.

The Association supported legislation introduced by Rep. Timothy J. Penny (D-MN) and Sen. William S. Cohen (R-ME) that would defer Stafford Student Loans (GSL and Perkins) until residents finish their training. Current law limits deferment to two years.

OTHER LEGISLATIVE ISSUES

The Association monitored legislation on a number of other issues in 1990, including reauthorization of the NIH, women's health, VA physician pay reform, regulation of radionuclides, scientific misconduct, mandatory health insurance, protection of animal research facilities, and a variety of tax issues ranging from the deductibility of student loan interest to tax-exempt bond financing.

GOVERNMENTAL RELATIONS REPRESENTATIVES (GRR)

The AAMC and the Association of Academic Health Centers continued joint sponsorship of the GRR, whose members have institutional responsibility for federal legislative and regulatory matters. Members of the GRR are designated by academic health center chief executive officers, medical school deans, and teaching hospital chief executives.

The GRR held three meetings in Washington, D.C. to foster a better understanding of the legislative process and the role that academic medical centers can play in that process, to update members on the status of pending legislative issues, and to facilitate GRR members' communications with congressional members and their staff. The meetings were held in conjunction with the Association of American Universities and the National Association of State Universities and Land Grant Colleges. Attendees heard presentations from congressional and agency staff on issues including access to health care, Medicare payments to hospitals for graduate medical education, the NIH grants review process, the Agency for Health Care Policy and Research, and the role of political action committees. GRR members also explored ways to interact more effectively with Congress and federal agencies.

AAMC TESTIMONY—1990

1. FY 1991 Appropriations for Department of Veterans' Affairs Veterans' Health Service and Research Administration. Presented by William Stoneman III, M.D., Dean, St. Louis University School of Medicine, Associate Vice President, St. Louis University Medical Center, before the House Committee on Veterans' Affairs, February 7, 1990.

2. FY 1991 Appropriations for Department of Veterans' Affairs Veterans' Health Service and Research Administration. Presented by Robert H. Waldman, M.D., Dean, University of Nebraska College of Medicine, before the Senate Committee on Veterans' Affairs, February 23, 1990.

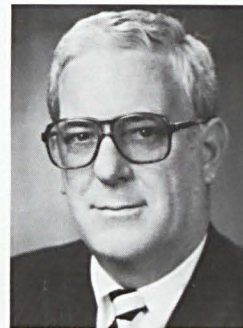
3. Restoration of the Deductibility of Interest on Educational Loans. Submitted by The Student Loan Interest Deduction Restoration Coalition to the House Ways and Means Subcommittee on Select Revenue Measures, February 22, 1990.

4. Positions on the Administration's FY 1991 Budget Proposals to Reduce the Indirect Medical Education (IME) Adjustment, Direct Medical Education Payments and Hospital Outpatient Payments. Presented by Eric B. Munson, Executive Director, University of North Carolina Hospitals, before the House Ways and Means Subcommittee on Health, February 28, 1990.

5. The Administration's FY 1991 Budget For Medical Research with additional comments on health manpower, Medicare, and VA funding. Presented by John F. Sherman, Ph.D., Executive Vice President, Association of American Medical Colleges, before the House Budget Committee Task Force on Human Resources, March 13, 1990.

6. Positions on the Administration's FY 1991 Budget Proposals. Submitted to the Senate Finance Committee, March 22, 1990.

7. FY 1991 Appropriations for the Department of Health and Human Services. Presented by Joe D. Coulter, Ph.D., Chairman, Department of Anatomy, University of Iowa College of Medicine and Chairman, Council of Academic Societies, Association of American Medical Colleges, before the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Agencies, March 27, 1990.



William Stoneman, III, M.D., testified on the FY 1991 appropriations for the VA before the House Committee on Veterans' Affairs.



Robert H. Waldman, M.D., testified before the Senate Committee on Veterans' Affairs on FY 1991 appropriations for the VA.



Eric B. Munson testified before the House Ways and Means Subcommittee on Health on budget proposals to reduce the indirect medical education adjustment, direct medical education payments, and hospital outpatient payments.



David Korn, M.D., appeared before the Senate Committee on Veterans' Affairs on the future structure of veterans' health care.



Emery A. Wilson, M.D., testified on the FY 1991 appropriations for the Department of Health and Human Services before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies.



Laurence Finberg, M.D., appeared before the House Appropriations Subcommittee on VA-HUD-Independent Agencies regarding VA medical care and health research.

8. Department of Veterans' Affairs Commission on the Future Structure of Veterans' Health Care. Presented by David Korn, M.D., Dean, Stanford University School of Medicine, before the Senate Committee on Veterans' Affairs, March 28, 1990.

9. Fetal Tissue Transplantation Research. Submitted to the Energy and Commerce House Subcommittee on Health and the Environment, April 2, 1990.

10. Reauthorization of the National Health Service Corps. Submitted to the House Energy and Commerce Subcommittee on Health and the Environment, April 18, 1990.

11. FY 1991 Appropriations for the Department of Health and Human Services. Presented by Emery A. Wilson, M.D., Vice Chancellor for Clinical Professional Services and Dean, University of Kentucky College of Medicine, Lexington, Kentucky before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, April 19, 1990.

12. FY 1991 Department of Veterans' Affairs Medical Care and Health Research Appropriations. Presented by Laurence Finberg, M.D., Dean, College of Medicine, State University of New York, Health Science Center at Brooklyn before the House Appropriations Subcommittee on VA-HUD-Independent Agencies, May 2, 1990.

13. FY 1991 Department of Veterans' Affairs Medical Care and Health Research Appropriations. Presented by Darryl Williams, M.D., Dean, Louisiana State University School of Medicine in Shreveport before the Senate Appropriations Subcommittee on VA-HUD-Independent Agencies, May 17, 1990.

14. The Health Status and Needs of Minorities in the 1990's. Submitted to the House Energy and Commerce Subcommittee on Health and the Environment, June 8, 1990.

15. S.2701 A Bill to Reform Special Pay for VA Physicians. Presented by I. Dodd Wilson, M.D., Dean, University of Arkansas College of Medicine before the Senate Veterans' Affairs Committee, June 14, 1990.

FINANCIAL STATEMENT

REPORT OF THE TREASURER

Fiscal year 1989-90 was one of substantial improvement in the Association's financial health. The positive outcome continues the trend of the past decade.

HIGHLIGHTS

- The AAMC maintained a balanced budget with roughly a \$340,000 excess of unrestricted revenues over expenditures and transfers.
- The value of the Association's unrestricted fund balances or "equity capital" as of June 30, 1990 was approximately \$19.6 million, a \$4 million increase over last year's balances.
- An excellent investment climate helped push the market value of the Association's investments to an all time high of roughly \$25.9 million, an increase of \$5.2 million over the prior year.
- A \$34.9 million tax-exempt financing strategy for the Association's new headquarters building was successfully completed. Standard & Poor's Corporation rated the tax-exempt bonds "AA-". The favorable rating significantly reduced borrowing cost.

OPERATING RESULTS

Unrestricted income earned from operations totaled \$21,027,606, an increase of \$6,263,944 over the prior fiscal year. The significant growth in revenues was due to a membership dues increase instituted in 1989-90, an 8.7% increase in medical school applicant processing coupled with a 9.5% rise in Medical College Admission Test services, and a \$774,372 increase in investment income. Income received from restricted grants, contracts, and programs was \$2,006,071.

Unrestricted expenditures totaled \$15,454,129, an increase of \$1,542,214 or 11% over the amount expended a year earlier, but roughly \$250,000 below the budget. The expenditure increase in fiscal year 1989-90 reflects filling new positions designated in the Association's strategic plan, and raising professional staff salaries to a competitive market level.

Expenditures from Executive Council designated funds, including \$771,851 expended for the Medical College Admission Test revision, totaled \$914,365. Restricted grants, contracts, and programs expenditures totaled \$1,793,507.

Fiscal year 1989-90 plant fund expenditures totaled \$714,050. Roughly \$320,000 was expended for purposes related to the new headquarters building tax-exempt financing, and \$385,653 was expended for micro-computers and peripheral data processing equipment.



BALANCE SHEET

June 30, 1990

ASSETS

Current Funds:

Cash and cash equivalents	\$1,489,096
U.S. Government contract costs receivable	196,640
Accounts receivable—other	391,875
Investments	25,749,063
Supplies, deposits and prepaid expenses	226,556
Notes receivable	593,609
Total current funds	<u>28,646,839</u>

Plant funds:

Investment in plant:	
Land	11,001,742
Building	795,916
Furniture and equipment	3,449,094
	<u>15,246,752</u>

Less accumulated depreciation (\$2,122,276)

Total net investment in plant **13,124,476**

Due from current funds	5,233,118
Other assets	683,146
Escrow deposit	500,000
Construction in progress	3,679,418
Deposits with trustee	20,299,780
Total plant funds	<u>43,519,938</u>

**LIABILITIES
AND FUND
BALANCES**

Current Funds:

Accounts payable and accrued expenses	1,174,921
Custodial funds held for related parties	804,966
Due to plant funds	5,233,118
Deferred revenue	4,424,115
Deferred compensation	1,737,506
Total liabilities	<u>13,374,626</u>

Unrestricted fund balance	12,223,390
Designated fund balance	1,875,675
Restricted fund balance	1,173,148

Total current fund balances **15,272,213**

Total current funds **28,646,839**

Plant funds:

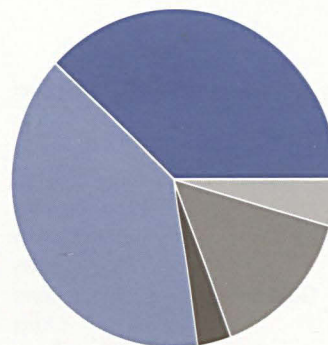
Accounts payable	\$393,094
Accrued interest expense	934,293
Bonds payable, net	34,391,549
Total liabilities	35,718,936

Fund balances:	
Investment in plant	2,312,359
Unexpanded—unrestricted	5,488,643

Total plant fund balances **7,801,002**

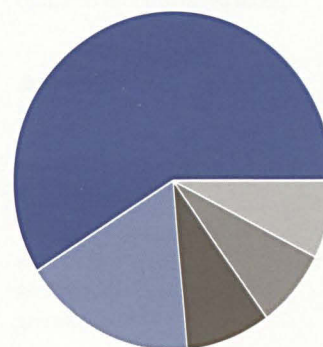
Total plant funds **\$43,519,938**

**UNRESTRICTED OPERATING REVENUES
FOR YEAR ENDED JUNE 30, 1990**



- Dues—38.1%
- Service Programs—39.4%
- Publications—3.2%
- Investment Income—14.8%
- Other—4.5%

**UNRESTRICTED OPERATING EXPENSE
FOR YEAR ENDED JUNE 30, 1990**



- Salaries & Related—59.0%
- Services—17.4%
- Occupancy Costs—8.5%
- Supplies & Other—7.5%
- Travel & Related—7.6%

STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN
FUND BALANCES FOR THE YEAR ENDED JUNE 30, 1990

	<i>Current</i>			Total Current Funds	Plant Funds	Total Funds
	Unrestricted	Designated	Restricted			
Revenue:						
Dues:	\$ 8,016,813	—	—	\$ 8,016,813	—	\$ 8,016,813
Service Programs	8,279,464	—	—	8,279,464	—	8,279,464
Journal of Academic Medicine	216,339	—	—	216,339	—	216,339
Other publications	461,853	—	—	461,853	—	461,853
Investment income	3,115,334	—	—	3,115,334	123,092	3,238,426
Private grants	—	—	784,357	784,357	—	784,357
Government contracts and grants	96,828	—	342,111	438,939	—	438,939
Other	840,975	—	879,603	1,720,578	—	1,720,578
Total revenues	21,027,606	—	2,006,071	23,033,677	123,092	23,156,769
Expenses:						
Division administration and programs:						
Institutional planning and development	1,555,476	—	678,691	2,234,167	—	2,234,167
Governmental relations	555,102	—	38,048	593,150	—	593,150
Biomedical research	494,749	—	—	494,749	—	494,749
Academic affairs	3,574,081	—	234,710	3,808,791	—	3,808,791
Minority affairs	293,881	—	230,005	523,886	—	523,886
Clinical services	673,026	—	198,224	871,250	—	871,250
Communications	540,246	—	—	540,246	—	540,246
Publications	551,804	—	—	551,804	—	551,804
Sub-council organizations	249,807	—	266,424	516,231	—	516,231
Liaison committees	182,434	—	—	182,434	—	182,434
Special studies	68,270	771,851	—	840,121	—	840,121
Special programs and meetings	149,682	—	—	149,682	—	149,682
	8,888,558	771,851	1,646,102	11,306,511	—	11,306,511
Administration and general:						
Office of the President	1,066,786	35,560	147,405	1,249,751	—	1,249,751
Office of the Executive Vice President	390,837	—	—	390,837	—	390,837
Office of the Vice President GME	207,129	—	—	207,129	—	207,129
Governing boards	390,352	—	—	390,352	—	390,352
Administrative services	1,030,834	—	—	1,030,834	—	1,030,834
Computer services	1,520,238	24,089	—	1,544,327	215,374	1,759,701
General expenses	1,773,102	82,865	—	1,855,967	498,676	2,354,643
Annual meeting	186,293	—	—	186,293	—	186,293
	6,565,571	142,514	147,405	6,855,490	714,050	7,569,540
Total expenses	15,454,129	914,365	1,793,507	18,162,001	714,050	18,876,051
Excess of revenues and other additions over (under) expenditures and other deductions	5,573,477	(914,365)	212,564	4,871,676	(590,958)	4,280,718
Transfers and other additions	(5,233,583)	1,368,000	—	(3,865,583)	3,865,583	—
Net increase (decrease) to fund balances	339,894	453,635	212,564	1,006,093	3,274,625	4,280,718
Fund balances, beginning of year	11,883,496	1,422,040	960,584	14,266,120	4,526,377	18,792,497
Fund balances, end of year	\$ 12,223,390	\$ 1,875,675	\$ 1,173,148	\$ 15,272,213	\$ 7,801,002	\$ 23,073,215

PRIVATE FOUNDATION SUPPORT**Baxter Foundation****Burroughs Wellcome Fund**

- *Support for the Annual AAMC Award for Distinguished Research in Biomedical Sciences*

Commonwealth Fund

- *A four-year award to develop a better policy analysis capability for teaching hospitals (\$496,000)*

Culpeper Foundation

- *A three-year award to assess the state of curriculum revisions in U.S. medical schools (\$947,580)*

- *A four-year award to enhance the Commonwealth Fund Fellowship Program in Academic Medicine for Minority Students (\$231,000)*

Howard Hughes Medical Institute

- *A five-year award to monitor careers of medical students who have participated in HHMI's training programs (\$480,000)*

Robert Wood Johnson Foundation

- *A four-year award for the preparation and publication of information on minorities in medical education (\$50,000)*

Henry J. Kaiser Family Foundation

- *Award to support administration of the Kaiser Family Foundation Faculty Scholars in General Internal Medicine program (\$481,375)*
- *A three-year award for the establishment of an advisory committee for the New Pathways Program at Harvard Medical School (\$114,000)*
- *A one-year award to support work to identify previous, current, and potential future activities by medical schools in the field of health promotion and disease prevention (\$30,000)*

W. K. Kellogg Foundation

- *A one-year award to develop a symposium entitled "Rural Health: A Challenge for Medical Education" (\$87,510)*

Macy Foundation

- *A three-year award to strengthen minority activities at the AAMC (\$361,862)*

Pew Foundation

- *A three-year award in support of minority fellowships for participation in the Executive Development Seminars of the AAMC (\$33,000)*

FEDERALLY SPONSORED PROGRAMS**U.S. Department of Health and Human Services****Health Resources and Services Administration**

- *A six-year Health Careers Opportunities Program grant to conduct workshops on admissions, counseling, and early identification of potential underrepresented students (\$634,365)*
- *A three-year contract to analyze the practice patterns of post-graduate physicians (\$285,636)*

National Center for Health Services Resources

- *A one-year grant to assess the effect of AIDS and Medical Residency Selection (\$72,100)*

National Institutes of Health

- *A five-year contract for the continued maintenance and development of the faculty roster database system and for the conduct of policy studies (\$535,470)*

CORPORATE GRANTS

The following corporations support the general operations of the Association as sustaining and contributing members:

Merck & Co., Inc.

Warner Lambert Foundation

COMMITTEES & PROFESSIONAL DEVELOPMENT GROUPS

AAMC COMMITTEES

The Executive Council and Administrative Boards make extensive use of committees of AAMC constituents to guide their deliberations on key policy matters and to provide oversight for the AAMC operations.

AAMC/ALPHA OMEGA ALPHA DISTINGUISHED TEACHER AWARD COMMITTEE

Selects recipients for two teaching awards

Chairman, Basic Science Award

Harvey V. Sparks, M.D.
Michigan State University
College of Human Medicine
East Lansing

Carol Aschenbrenner, M.D.
University of Iowa
College of Medicine, Iowa City

John H. Wallace, Ph.D.
University of Louisville
School of Medicine, Louisville

Chairman, Clinical Science Award

Harry N. Beaty, M.D.
Northwestern University
Medical School, Chicago

John P. Geyman, M.D.
University of Washington
School of Medicine, Seattle

Donald Medearis, Jr., M.D.
Massachusetts General Hospital,
Boston

RESEARCH AWARD COMMITTEE

Chooses recipient for annual AAMC Award for Distinguished Research in the Biomedical Sciences

Chairman

Samuel Hellman, M.D.
University of Chicago
Pritzker School of Medicine,
Chicago

Stephen Ayres, M.D.
Virginia Commonwealth University
Medical College of Virginia,
Richmond

Mordecai P. Blaustein, M.D.
University of Maryland
School of Medicine, Baltimore

B. R. Brinkley, M.D.
University of Alabama
School of Medicine, Birmingham

Kurt Ebner, Ph.D.
University of Kansas Medical Center
School of Medicine, Kansas City

David Skinner, M.D.
The New York Hospital, New York

FLEXNER AWARD COMMITTEE

Chooses recipient of Abraham Flexner Award for Distinguished Service to Medical Education

Chairman

Robert Berne, M.D.
University of Virginia
School of Medicine, Richmond

Rosalie Burns, M.D.
Medical College of Pennsylvania,
Philadelphia

J. Richard Gaintner, M.D.
New England Deaconess Hospital,
Boston

Joseph E. Johnson III, M.D.
University of Michigan
Medical School, Ann Arbor

William Stoneman III, M.D.
St. Louis University
School of Medicine, St. Louis

RESOLUTIONS COMMITTEE

Receives and acts on resolutions for presentation to the Assembly

Chairman

S. Craighead Alexander, M.D.
University of Wisconsin
Medical School, Madison

Spencer Foreman, M.D.
Montefiore Medical Center

Robert Summitt, M.D.
University of Tennessee, Memphis,
College of Medicine

Lawrence Tsen
University of Kansas
School of Medicine, Kansas City

**AD HOC COMMITTEE ON
MISCONDUCT AND
CONFLICT OF INTEREST IN
RESEARCH**

*Recommends policy positions
and initiatives for the
Association*

Chairman

Michael J. Jackson, Ph.D.*
George Washington University
School of Medicine and Health
Sciences, Washington, D.C.

William T. Butler, M.D.
Baylor College of Medicine,
Houston

Joe Dan Coulter, Ph.D.
University of Iowa
College of Medicine, Iowa City

Spencer Foreman, M.D.
Montefiore Medical Center,
New York

Ernst R. Jaffé, M.D.
Albert Einstein College of Medicine,
New York

Max Poll
Barnes Hospital, St. Louis

Robert E. Tranquada, M.D.
University of Southern California
School of Medicine, Los Angeles

* Resigned effective September 1,
1990 to become Executive Director of
the Federation of American Societies of
Experimental Biology

**AD HOC COMMITTEE ON
NURSING SERVICES AND THE
TEACHING HOSPITAL**

*To address the special problems
facing teaching hospitals in the
recruitment, organization, and
employment of nurses and the
Association's role in assisting its
members to solve these
problems*

Chairman

Jerome H. Grossman, M.D.
New England Medical Center,
Boston

James A. Block, M.D.
University Hospitals of Cleveland,
Cleveland

C. McCollister Evarts, M.D.
Pennsylvania State University
College of Medicine, Hershey

Patricia Gibbons
Yale-New Haven Hospital,
New Haven

R. Edward Howell
Medical College of Georgia
Hospitals and Clinics, Augusta

Anthony L. Imbombo, M.D.
University of Maryland
School of Medicine, Baltimore

Max Poll
Barnes Hospital, St. Louis

Helen Ripple
The Medical Center at the
University of California,
San Francisco

Barbara A. Small
Veterans' Administration Medical
Center, Durham, North Carolina

Carolyn Smeltzer
University of Chicago Hospitals,
Chicago

I. Dodd Wilson, M.D.
University of Arkansas
College of Medicine, Little Rock

**ADVISORY COMMITTEE ON
MEDICARE REGULATIONS FOR
PAYMENT OF PHYSICIANS IN
TEACHING HOSPITALS**

*To review and make recommen-
dations on proposed Medicare
rules determining payments for
professional medical services of
teaching physicians*

Chairman

Hiram Polk, Jr., M.D.
University of Louisville
School of Medicine, Louisville

L. Thompson Bowles, M.D., Ph.D.
George Washington University
School of Medicine and Health
Sciences, Washington, D.C.

Edward N. Brandt, M.D., Ph.D.
University of Oklahoma
School of Medicine, Oklahoma City

Ira C. Clark
Jackson Memorial Hospital, Miami

Jack M. Colwill, M.D.
University of Missouri, Columbia
School of Medicine, Columbia

Martin G. Dillard, M.D.
Howard University School of
Medicine, Washington, D.C.

J. Richard Gaintner, M.D.
New England Deaconess Hospital,
Boston

Richard A. Grossi, M.D.
The Johns Hopkins University
School of Medicine, Baltimore

Benjamin F. Keady
University of Texas Medical School
at San Antonio

Herbert Pardes, M.D.
Columbia University College of
Physicians and Surgeons, New York

C. Edward Schwartz
University of Nebraska Hospital,
Omaha

Bruce Steinhauer, M.D.
Henry Ford Hospital, Detroit

Stephen Wang, M.D.
Morristown Memorial Hospital,
Morristown

I. Dodd Wilson, M.D.
University of Arkansas
College of Medicine, Little Rock

**MANAGEMENT EDUCATION
PROGRAMS PLANNING
COMMITTEE**

*Designs and implements
seminars to assist constituents in
development of managerial skills*

Chairman

William T. Butler, M.D.
Baylor College of Medicine,
Houston

Anthony L. Barbato, M.D.
Loyola University of Chicago Stritch
School of Medicine, Chicago

Robert L. Friedlander, M.D.
Union University
Schenectady

Jerome H. Grossman, M.D.
New England Medical Center,
Boston

John W. Hennessey, Ph.D.
University of Vermont, Burlington

William B. Kerr
The Medical Center at the
University of California,
San Francisco

John D. Stobo, M.D.
The Johns Hopkins University
School of Medicine, Baltimore

Robert H. Waldman, M.D.
University of Nebraska
College of Medicine, Omaha

NOMINATING COMMITTEE

*Charged with nominating
candidates for positions as
officers of the Assembly and
members of the Executive
Council*

Chairman

David M. Brown, M.D.
University of Minnesota
Medical School, Minneapolis

Gary Gambuti
St. Luke's-Roosevelt Hospital,
New York

Myron Genel, M.D.
Yale University School of Medicine,
New Haven

Glenn C. Hamilton, M.D.
Wright State University
School of Medicine, Dayton

Kenneth I. Shine, M.D.
University of California, Los Angeles,
School of Medicine

**ASSESSING CHANGE IN
MEDICAL EDUCATION
(ACME) ADVISORY GROUP**

Provides advice to the project staff on survey and implementation strategies, data analysis, report publication

Chairman

Harry N. Beaty, M.D.
Northwestern University
Medical School, Chicago

Stephen Abrahamson, Ph.D.
University of Southern California
School of Medicine, Los Angeles

John E. Albers, M.D.
University of Cincinnati, Cincinnati

Joel J. Alpert, M.D.
Boston University
School of Medicine, Boston

Samuel W. Bloom, Ph.D.
Mount Sinai School of Medicine of
the City University of New York,
New York

George T. Bryan, M.D.
University of Texas Medical School
at Galveston

Susan Carver, M.D.
Harvard Medical School, Cambridge

Jules Cohen, M.D.
University of Rochester
School of Medicine, Rochester

Norman D. Kalbfleisch, M.D.
Oregon Health Sciences University
School of Medicine, Portland

Thomas C. King, M.D.
Columbia-Presbyterian
Medical Center, New York

Page S. Morahan, Ph.D.
Medical College of Pennsylvania,
Philadelphia

Carlos A. Moreno, M.D.
University of Texas Medical School
at San Antonio

Darwin J. Prockop, M.D., Ph.D.
Jefferson Medical College of Thomas
Jefferson University, Philadelphia

Caroline Reich
Emory University
School of Medicine, Atlanta

Stanford A. Roman, Jr., M.D.
New York City Health & Hospitals
Corp., New York

Cornelius Rosse, M.D., D.Sc.
University of Washington
School of Medicine, Seattle

Norman G. Sansing, Ph.D.
University of Georgia, Atlanta

Henry M. Seidel, M.D.
The Johns Hopkins University
School of Medicine, Baltimore

Eugene L. Staples
University of Kansas Hospital,
Kansas City

Robert L. Volle, Ph.D.
National Board of Medical
Examiners, Philadelphia

John H. Wallace, Ph.D.
University of Louisville
School of Medicine, Louisville

John C. Weston, Ph.D.
Muhlenberg College, Allentown

**WOMEN IN MEDICINE
COORDINATING COMMITTEE**

*To advance the status and
develop the potential of women
in academic medicine*

Leah Dickstein, M.D.
University of Louisville
School of Medicine, Louisville

Alix I. Robinson, Ph.D.
State University of New York Health
Science Center at Syracuse

Gerry R. Schermerhorn, Ph.D.
Southern Illinois University
School of Medicine, Springfield

Jeannette South-Paul, M.D.
Uniformed Services University of the
Health Sciences, Bethesda

Lisa Staber
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OFFICE OF THE PRESIDENT

It is the individuals in an organization that give it heart and life. Two individuals who have done much to shape the Association over the past 16 years, John F. Sherman, Ph.D., executive vice president and Thomas J. Kennedy, Jr., M.D., associate vice president, retired June 30. Both will continue with the association as special consultants.

Dr. Sherman joined the AAMC in 1974 as vice president and director, Department of Planning and Policy Development after an 18 year tenure at the National Institutes of Health. Since

1987 he has been executive vice president of the Association. He has provided leadership across a broad array of issues including increased support for research funding, use of animals in education and research, conflict of interest in science, and medical informatics.

John F. Sherman, Ph.D.



Dr. Kennedy joined the Association in July 1976 as director of the AAMC's Department of Planning and Policy

Development after 24 years at the National Institutes of Health and two years at the National Academy of Science. His efforts to advance the nation's research enterprise and his analytical skills of complex legislative and regulatory issues have fostered a broader understanding of public policy concerns.

Thomas J. Kennedy, Jr., M.D.



Continuing the strong leadership in academic medicine for which the AAMC is noted, Robert G. Petersdorf, M.D., president, appointed Edward J. Stemmler, M.D., Robert G. Dunlop Professor of Medicine and dean emeritus, University of Pennsylvania Medical Center, executive vice president effective July 1, succeeding Dr. Sherman. Dr. Stemmler has been active in Association affairs for many years and was AAMC chairman in 1986-87.

Kathleen S. Turner was appointed vice president for special projects effective July 1. She joined the Association in 1976 in the Division of Biomedical Research. Two years later she moved into the President's Office as special assistant to the president and was named assistant vice president in 1987.

DIVISION OF INSTITUTIONAL PLANNING AND DEVELOPMENT

Robert F. Jones, Ph.D., was promoted to assistant vice president, Section for Institutional Studies in July. Dr. Jones has been with the Association for 13 years, first as a research associate and, since 1984, as director for Institutional Studies. In 1987, that program was made a separate section of the division. Dr. Jones is responsible for studies and projects to enhance institutional capability in planning and in the management of faculty resources. Currently he is working on a space management planning document. He also serves as executive secretary of the Group on Institutional Planning.

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