



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

Annual Report 1992-93

“
The ultimate
goal of the
Association
and its
members
is effective
health care of
our nation.

”

Front cover quotation:

Robert G. Petersdorf, M.D., "President's Message," 1987-88 Annual Report.

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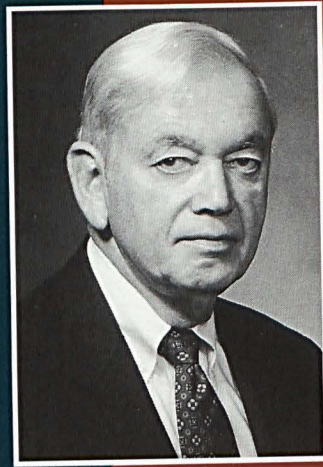
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Robert D. Bellows

President's Message

I announced my retirement as AAMC president at the Association's November 1992 Annual Meeting, and this will be my final annual report. Let me begin by thanking the entire constituency and our loyal and competent staff for their hard work and support during the past seven years. I am stepping down at a time of remarkable change and no small upheaval in the American health care system. At this writing it still is too early to tell whether and how the Clinton administration will bring costs under control and provide access to quality care to the millions of uninsured and underinsured people in this country. But changes have begun already—in both the academic and practice environments.

The AAMC has a proud tradition of leadership, rather than merely advocacy, for academic medicine. Now, at the dawn of what finally could be real health care reform, we can be justifiably proud that academic medicine is leading the larger medical community toward a physician workforce capable of caring for the American people in the 21st century.

Last October, the Executive Council approved the report of the AAMC Generalist Physician Task Force, adopting as policy the report's recommendation that U.S. medical schools set an overall, national goal that a majority of their graduates enter practice as general internists, general pediatricians or family physicians. By spring, the Association had opened the Office of Generalist Physician Programs and during the summer we offered the first Management Education Program to help medical schools enhance their generalist initiatives.

These efforts are only the first steps in what likely will be a difficult process of correcting the increasing trend toward subspecialization among our graduates. But they are steps in the right direction.

In June, the Association's governance brought to fruition the work of another constituent group, the AAMC Advisory Panel on Strategic Positioning for Health Care Reform. The panel members had drafted four position papers which the Council of Academic Societies, the Council of Teaching Hospitals and the Council of Deans discussed extensively at their spring meetings. The papers included a statement of goals and principles (the fundamental issues of health care reform); a paper on funding health-related research, an overview document, "Academic Medicine: The Cornerstone of the American Health Care System;" and a comprehensive paper on funding graduate medical education.

The GME paper was the most widely discussed of the four. It addresses very difficult issues of free-market versus regulatory solutions to the nation's physician supply problems. Some were concerned that, in calling for a National Physician Resources Commission to regulate supply and specialty distribution, we would cede too much power to government. Others warned that governmental intervention was inevitable

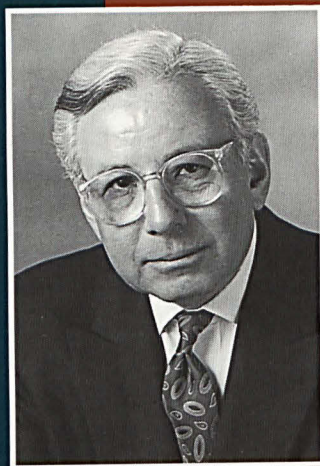
because market forces had not corrected the problems of physician supply. Should we in academic medicine fail to offer a more proactive plan, they maintained, government would force one on us.

Debate over this central question was intense but enlightened. It led to a compromise proposal in which market forces would be given time to effect a solution, with the regulatory powers of the commission brought into play only if the market fails to correct the problems, and only if an all-payer fund is created to help finance GME. In a splendid example of leadership, the Executive Council unanimously voted to adopt this version of the document, along with its three companions, as AAMC policy.

This example of unity is one the academic medicine community will need to repeat in the months and years ahead. Much has been said and written in the past two years about the need to reform the nation's health care system. In fact, the task probably is better defined as *forming* a new system, because the current apparatus cannot accurately be called a system—it does not serve the needs of a vast number of people. Academic medicine must navigate treacherous waters if it is to maintain a leadership position in the new world of American health care.

Difficult decisions lie ahead for this Association and my successor. The events of the past year offer hope that they can and will succeed, advancing our missions of education, research and patient care into the next century. I wish them the best of luck.

Robert G. Petersdorf, M.D.
AAMC President



Frederic M. Iversen, MD

Report of the Chairman

America's academic medical enterprise is one of the most dazzling success stories of the 20th century. Spurred by generous national investment, academic medical centers have trained a superb corps of physicians and scientists who have made stunning contributions to medicine and science and developed the most sophisticated patient care in the world.

Despite our immense and incomparable success, a grateful nation does not lie at our feet. There is a growing sense that we have failed to deliver on important elements of the social contract into which we entered implicitly by accepting today's generous support. The perception is that we have received far more than our share of public support and should be held to a far higher standard of performance. The old observation says it all: "From those to whom much is given, much is expected."

There are clear signs of social discontent all around us, a discontent manifest in public policy decisions that have chipped away at the supports that have sustained the academic enterprise for decades. We can choose to see the dissolution of the old agreements as deals reneged on. We can feel misunderstood, disaffected or even angry. Or we can consider the possibility that we might have missed some of the opportunities and obligations presented to us by society in exchange for its lavish investment in our enterprise.

Academic medical centers do well for those who find their way past our doors and deliver miracles as a matter of course. Yet within a stone's throw of the miracles are communities whose health is little better than that of third-world countries, and beyond the ring of comfortable suburbs are areas of rural isolation equally bereft. These communities have too few physicians to meet their basic health needs, and urban communities in particular carry the additional burdens of complex social, economic and environmental problems. Poverty, homelessness, unemployment, crime, violence and isolation undermine health and demand a response beyond the traditional ministries of health professionals and institutions.

Addressing the unmet needs of the nation's underserved communities is an area of social responsibility and commitment, which, on the face of it, does not belong wholly with the academic community but nonetheless is most appropriately undertaken by us. Among society's institutions, we are perhaps the only one with the capacity to get the job done.

In my view our role is not merely catalytic, limited to exhorting or assisting others in doing what needs to be done. It is an aggressively active role, in which academic medical centers make major institutional commitments to building

and sustaining unique community-based delivery systems that are capable of dealing with the complex problems of the disadvantaged; linked to the secondary, tertiary and post-hospital care systems; devoted to training health professionals who are committed to serving the isolated and the poor; and capable of studying illness and social pathology in ways that shed light on and address those problems.

Pursuing and valuing this agenda is not somebody else's job. It belongs to all of us who represent American academic medicine. We must find ways to allow, encourage, and empower our faculty and staff to undertake this aggressive program of community and public service. We must value, support and reward their contributions in tangible ways within the academic medical center through financial resources, recognition and faculty advancement.

If we do not provide the leadership to pursue and foster this agenda, it will be clear to those around us and to those who work for us that our rhetoric is only that. An important, indeed critical, job will go undone. An opportunity will have been missed. And all of us, in academic medicine, in the underserved communities and throughout American society, will be the poorer for it.

Spencer Foreman, M.D.
AAMC Chair

Governance and Membership

The Executive Council, the governing body of the Association, has 30 voting members. The Council leadership consists of the chair, chair-elect, immediate past-chair and president of the Association; the chair, chair-elect, and immediate past chair of each council administrative board—Council of Deans (COD), Council of Teaching Hospitals (COTH) and Council of Academic Societies (CAS); the chair and chair-elect of both the Organization of Student Representatives (OSR) and the Organization of Resident Representatives (ORR); 12 elected members—three each from the COTH and CAS and six from the COD; and a Distinguished Service Member.

The Association's legislative body is its Assembly, comprising all 126 members of the COD, 126 members of the COTH, 90 members of the CAS and 12 members each from the OSR and the ORR.

Each year, members and staff of the U.S. Congress, 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 1992-93, AAMC leaders heard from the following speakers:

Philip Lee, M.D.

Professor of Social Medicine
University of California, San Francisco
Chair, Physician Payment Review
Commission

Sheila Burke

Chief of Staff,
Senate Minority Leader
Senator Robert Dole (R-Ks.)

AAMC Governance



Chair

Spencer Foreman, M.D.*
Montefiore Medical Center



Chair-elect

Stuart Bondurant, M.D.*
University of North Carolina at
Chapel Hill School of Medicine



Immediate Past Chair

J. Robert Buchanan, M.D.*
Massachusetts General Hospital

President

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

Distinguished Service Member

D. Kay Clawson, M.D.*
University of Kansas School of Medicine

** Executive Council Member*

**Council of Deans
Administrative Board**



Chair

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

Chair-elect

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

Immediate Past Chair
(vacant)

Jordan J. Cohen, M.D.*
State University of New York at Stony Brook
Health Sciences Center
School of Medicine

Richard A. Cooper, M.D.*
Medical College of Wisconsin

Charles H. Epps, Jr., M.D.
Howard University
College of Medicine

James A. Hallock, M.D.*
East Carolina University
School of Medicine

Michael E. Johns, M.D.*
The Johns Hopkins University
School of Medicine

Donald R. Kmetz, M.D.*
University of Louisville
School of Medicine

Joseph B. Martin, M.D., Ph.D. (1)
University of California
San Francisco School of Medicine

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

William A. Peck, M.D.
Washington University
School of Medicine

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

(1) Resigned, June, 1993

* Executive Council Member

**Council of Teaching Hospitals
Administrative Board**



Chair

William B. Kerr*
University of California,
San Francisco Medical Center

Chair-elect

Charles M. O'Brien, Jr.*
The Western Pennsylvania Hospital

Immediate Past Chair

C. Edward Schwartz*
University of Nebraska Hospital

Ron J. Anderson, M.D.
Parkland Memorial Hospital

Frank A. Butler*
University Hospital,
University of Kentucky Medical Center

Jose R. Coronado* (2)
Audie L. Murphy Memorial
Veterans Hospital

David D'Eramo, Ph.D.
St. Francis Hospital & Medical Center

John D. Forsyth
University of Michigan Hospitals

R. Edward Howell*
Medical College of Georgia
Hospitals and Clinics

William I. Jenkins
Sinai Samaritan Health Center

Ralph W. Muller*
University of Chicago Hospitals

Robert G. Newman, M.D.
Beth Israel Medical Center

Edmond F. Notebaert
Children's Hospital of Philadelphia

Ronald R. Peterson
The Francis Scott Key
Medical Center

Lorraine Tredge
Bronx Municipal Hospital Center

(2) Resigned, July 1993

**Council of Academic Societies
Administrative Board**



Chair

S. Craighead Alexander, M.D.*
Hahnemann University
School of Medicine

Chair-elect

George A. Hedge, Ph.D.*
West Virginia University
School of Medicine

Immediate Past Chair

Kenneth I. Berns, M.D.*
Cornell University Medical College

Rita Charon, M.D.
Columbia University
College of Physicians and Surgeons

William E. Easterling, M.D.
University of North Carolina
School of Medicine

Kurt E. Ebner, Ph.D.
University of Kansas Medical Center

Paul J. Friedman, M.D.*
University of California, San Diego
School of Medicine

Robert O. Kelley, Ph.D.
University of New Mexico
School of Medicine

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

David W. Nierenberg, M.D.*
Dartmouth-Hitchcock Medical Center

Vivian W. Pinn, M.D.*
National Institutes of Health

Beverly Rowley, Ph.D.
Maricopa Medical Center

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

Organization of Resident Representatives Administrative Board



Chair

Joseph S. Auteri, M.D.*
Columbia-Presbyterian Medical Center

Chair-elect

Michele C. Parker, M.D.*
UCLA Family Health Center

Immediate Past Chair

Bernarda M. Zenker, M.D.
University of Oklahoma
School of Medicine

Denise Dupras, M.D.
Mayo Graduate School of Medicine

Cathy Halprin, M.D.
Rush-Presbyterian-St. Luke's
Medical Center

Mary Elise Hodson, M.D.
Medical Associates, Indianapolis

Joshua Port, M.D.
University of Pittsburgh Hospital

Louis Profeta, M.D.
University of Pittsburgh Hospital

Barbara Tardiff, M.D.
Oregon Health Sciences University

**Executive Council Member*

Organization of Student Representatives Administrative Board



Chair

David Graham, M.D.*
East Carolina University
School of Medicine

Chair-elect

Bruce Weinstein*
University of Connecticut
School of Medicine

Immediate Past Chair

Erik Gundersen
University of Wisconsin
School of Medicine

Elizabeth Amick, M.D.
University of Colorado School of Medicine

Kent Bream
University of Maryland
School of Medicine

Christopher Cabell
Duke University
School of Medicine

Tylys Chang, M.D.
University of Pittsburgh School of Medicine

Kyle Kircher
Mayo Medical School

Greg Kirk, M.D.
University of Oklahoma College of Medicine

Michael A. Pilla
University of Pennsylvania
School of Medicine

Vanessa Pinto
Cornell University Medical College

Jaishree Schley
University of Illinois, Urbana
School of Medicine

Constituents

The AAMC's constituents are

- 126 accredited U.S. medical schools, each represented by its dean on the Council of Deans;
- 400 member teaching hospitals with substantial research and educational activities, including 72 Department of Veterans Affairs medical centers represented by their CEOs on the Council of Teaching Hospitals;
- 90 member academic and professional societies, each represented by two delegates to the Council of Academic Societies representing approximately 70,000 faculty members at member institutions;
- 126 students serving in the Organization of Student Representatives representing 65,000 students;
- 44 residents at U.S. medical schools and AAMC-member teaching hospitals appointed by members of clinical societies representing 68,000 residents;
- 16 Canadian medical schools as associate members;
- More than 700 individuals interested in medical education;
- Faculty members and administrators of medical colleges, teaching hospitals and academic medical centers who represent their institutions in groups of professionals with similar interests within the AAMC:

Group on Business Affairs

Group on Educational Affairs

Section on Resident Education

Group on Faculty Practice

Group on Institutional Planning

Group on Institutional Advancement

Group on Student Affairs

Minority Affairs Section

*Governmental Relations Representatives
(collaborative effort with the
Association of Academic Health
Centers)*

Women in Medicine

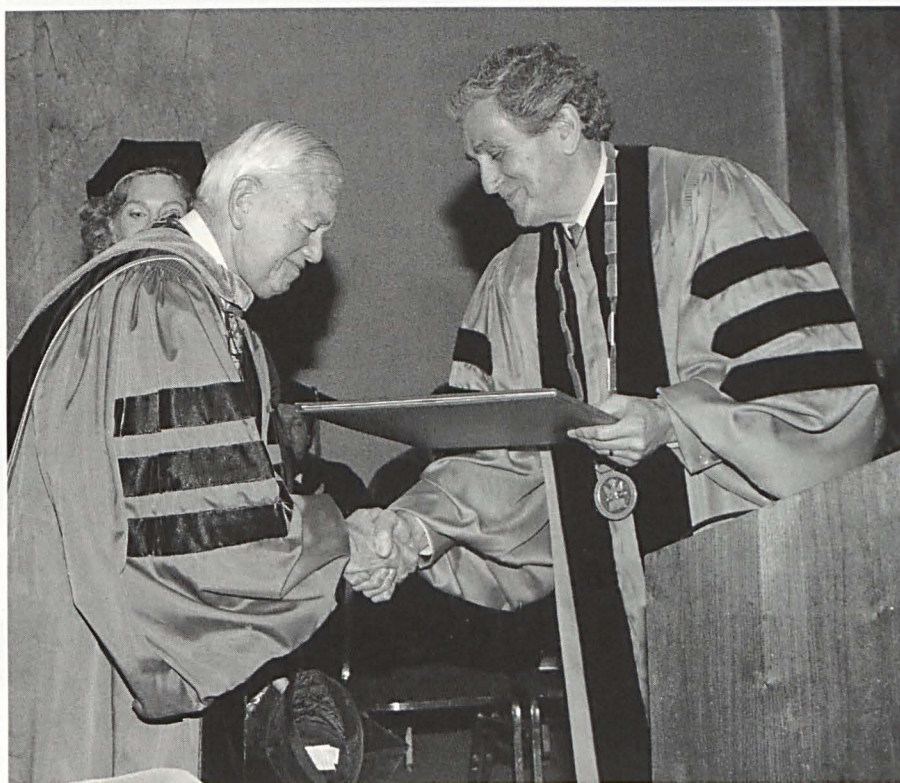
Office of the President

The AAMC president, although ultimately responsible to representatives of the member institutions, is *of and from* academic medicine and is expected to lead—to identify goals, to represent the community and, with the advice and consent of the Executive Council, to implement Association policy. The seven-year tenure of Robert G. Petersdorf, M.D., as AAMC president has been a period of great growth and change for the Association.

Some colleagues, on learning that he was a candidate for presidency, wondered whether Dr. Petersdorf, with his history of provoking controversial issues,

could succeed in this environment. That he has done so is attributable in part to his ability to continue to learn and to revise his ideas and opinions based on what he learns. He has led the AAMC in responding to the needs of academic medicine and, under his leadership, the AAMC has helped lead academic medicine in responding to the needs of society.

Dr. Petersdorf established a more comprehensive program of interaction with the federal government, combining the efforts of seasoned professional staff and involved, well-informed constituents. The AAMC frequently provides expert testimony and commentary for congressional and regulatory hearings, and is an active leader in advocacy for the research and patient care programs of the National Institutes of Health and the Department of Veterans Affairs, Medicare reimbursement for both hospitals and academic physicians, and funding for graduate medical education and student financial aid programs.



For his efforts to keep American medical education "second to none," Tufts University School of Medicine awarded Dr. Petersdorf a Doctor of Science, *Honoris Causa* degree presented at graduation ceremonies by Tufts President John DiBiaggio, D.D.S. (right).

For four years, the AAMC was in the vanguard of the campaign to lift promising fetal tissue transplantation research from the political quagmire of abortion. The Association's efforts included placing newspaper editorials, organizing constituent visits to Congress and, when Congress failed to override a presidential veto, suing the Secretary of Health and Human Services to lift the fetal tissue research ban. Although the legislative campaign failed to reverse the Bush administration's ban, it firmly established the AAMC among the champions of such research. And Dr. Petersdorf was among those President Clinton invited to the White House to witness his signing of an

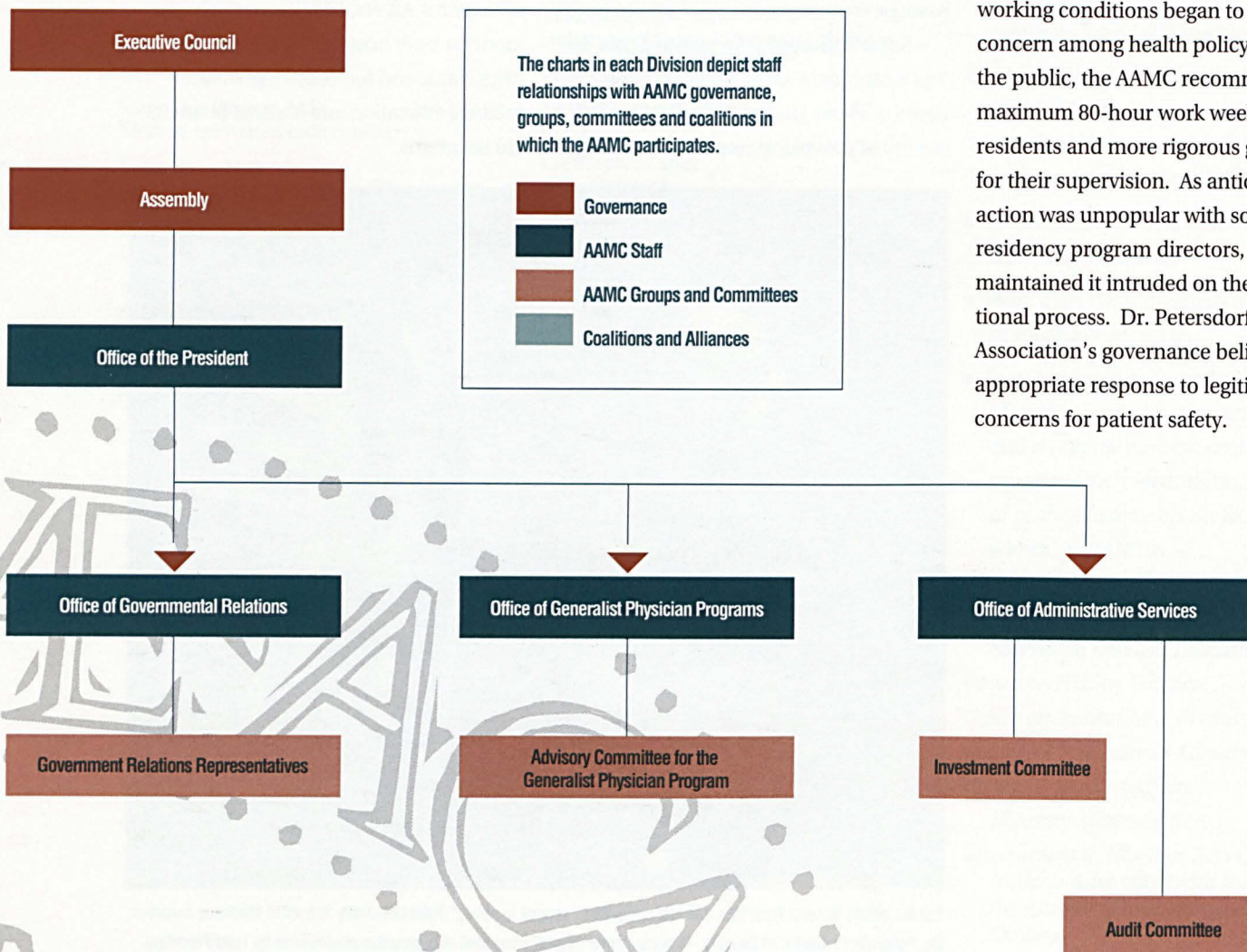
executive memorandum lifting the fetal tissue research ban.

Strategic planning, issues management, priority setting and, most important, increased participation by constituents have broadened and strengthened programs and activities within the AAMC. Members of the AAMC Advisory Panel on Biomedical Research meet to analyze information and recommend policy to the Executive Council on matters of research funding; promoting ethical standards and dealing with misconduct; and defining appropriate relationships among industry, academe and government.

In 1991, the methods by which government reimburses academic

institutions for the indirect costs associated with performing government-funded research came under intense scrutiny and criticism. Indirect costs were a complex web—each institution negotiated its own reimbursement rate with the federal government and accounting guidelines were inconsistent. The confusion over what constitutes a legitimate research-related expense and the ensuing backlash over what proved to be unintentional misallocation of indirect cost reimbursements threatened to hamstring several major institutions' research programs. The APBR has led the Association in its efforts to help establish understandable definitions for reimbursable expenses and guidelines for reporting them.

In the 1980s, when housestaff working conditions began to create concern among health policy makers and the public, the AAMC recommended a maximum 80-hour work week for medical residents and more rigorous guidelines for their supervision. As anticipated, this action was unpopular with some residency program directors, who maintained it intruded on the educational process. Dr. Petersdorf and the Association's governance believed it an appropriate response to legitimate concerns for patient safety.



Last year, the Association faced an equally difficult decision in addressing the problem of specialty maldistribution. For nearly 20 years both Dr. Petersdorf and AAMC Vice President for Medical Student and Resident Education Robert H. Waldman, M.D., had written about the decline of the generalist specialties. After months of study, the AAMC Generalist Physician Task Force recommended that medical schools adopt an overall, national goal that a majority of their graduates enter the generalist specialties of family medicine, general internal medicine and general pediatrics.

The report acknowledged that to achieve this goal, medical schools would need to implement profound changes in admissions policy, curriculum, faculty and administrative structure. The report also pointed out that medical schools could not single-handedly solve the generalist shortage—that graduate medical education and, especially, the practice environment also must be examined with an eye to change. Such changes would be difficult and often painful.

These difficulties notwithstanding, the Executive Council adopted the generalist report as policy. In the months afterward, the Association began to implement the report's recommendations, including opening the Office of Generalist Physician Programs, holding the first Management Education Program on generalist initiatives, compiling data and bibliographies on existing generalist programs and working with government agencies and generalist organizations to encourage young doctors to enter these disciplines.

Another major initiative area has been academic medicine's response to the diversification of American society. The percentage of women among medical school enrollment has been increasing steadily for two decades. More women physicians are entering academic

careers, but many encounter difficulties in trying to advance. The Women in Medicine program has grown to require full-time staff. It provides information and assistance to junior and senior faculty through faculty mentoring networks for women students.

The percentage of women among medical school faculty has grown from 14.5 in 1975 to 23.7 in 1993. Five women currently are medical school deans (two of them on an interim basis). In 1975 there were none. The number of women associate deans is more than double what it was in 1975—their percentage has more than quadrupled—and this year's 405 female assistant deans represent more than 25 percent of all administrators at that level. Certainly the AAMC Women in Medicine program is not solely responsible for these advances. But it has been successful in creating and sustaining a comprehensive information and support network that has helped women in academic medicine cope with a difficult environment and acquire management and other skills needed to advance.

Members of some racial and ethnic minorities continue to suffer greater incidence of disease and early death than the majority population. Many are poor and have little access to health care and health information. They also have not been able to penetrate the medical profession in numbers proportional to their presence in the population at large.

In 1988, the Association created what today is the Division of Minority Health, Education and Prevention to identify ways academic medicine can improve the health of underserved populations and bring closer to parity the presence of underrepresented minorities among medical students, faculty and physicians. For the past two years, the AAMC Health Services Research Institute has sponsored a number of activities to enhance research opportunities for minority medical scientists and train them to win



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The Association is strong because it holds together a diverse community —

both within each academic medical center and among different academic medical centers — for an important common good: supporting, protecting, and nurturing academic medicine.

Developing a unified strategy to protect and support the multiple missions of our academic medical centers must be an important goal for the Association and its members.

”

J. Robert Buchanan, M.D.
AAMC Chair 1991-92

grants and successfully complete health services research projects.

This division has undertaken major initiatives to prepare more minority students for the rigors of medical school and to help minority physicians enter and advance in academic careers and function competitively in the research arena. Perhaps most visible among the Association's efforts in this area is *Project 3000 by 2000*, a major initiative to increase minority presence in U.S. medical schools by improving educational opportunities for minority students at every stage of the premedical "pipeline"—undergraduate, high school and even middle school and elementary school.

In the past decade, the advent of the so-called "animal rights" movement became a threat to the nation's biomedical research enterprise, as protests against any use of animals increased in frequency and intensity. These groups have targeted medical schools with tactics ranging from peaceful protests to assault, burglary, vandalism, arson and smear campaigns against researchers and laboratory personnel.

Ever cognizant of the importance of treating animals humanely, the AAMC recognized the need to staunchly defend their use in research when necessary to improve the health of animals as well as people. A 1990 AAMC study showed medical schools had suffered multimillion dollar losses from such attacks and had been forced to divert millions more to increased security and responding to legal challenges to their rights to use laboratory animals.

That same year, the Association led other science, health, education and patient advocate groups who support the humane and responsible use of animals in biomedical and behavioral research in forming the Saving Lives Coalition. The coalition published a technical assistance manual to help animal research facilities adhere to regulations, maintain security, manage crises and promote public understanding of the importance of animal research in fighting disease and fostering health in humans and animals.

The AAMC has continued its leadership role in the Saving Lives Coalition, organizing events and producing publications and other materials to inform Congress and the public of the vital need to continue such research. The group also sponsors a campaign to put patients in touch with researchers, to let them know their work is appreciated.

The AAMC has concerned itself increasingly with advancing institutional quality. New constituent groups, such as the Organization of Resident Representatives, the Group on Faculty Practice and the Section on Resident Education, offer opportunities for communication and professional development among more members of the community. The annual Research in Medical Education colloquy has become a showcase for educational innovation. Special publications and meetings help promote and explore such topics as the use of standardized patients in skills assessment, clinical education in the ambulatory setting and small-group and computer-assisted learning methods.

The AAMC encourages investigation of new applications for information technologies in both education and administration. In 1992, staff began design work on the MCAT Writing Sample Delivery System, which will give schools electronic access to essays written by their applicants. This year, plans for an Electronic Residency Application Service

were unveiled. The potential exists to link the Association and all its members via a computer network, greatly easing the slower and more cumbersome flow of paper.

In recent years, the degree and frequency of communication and interaction between the AAMC and its members has expanded and intensified. The complement of regular news instruments matured from a single weekly bulletin to include the monthly *AAMC Reporter*, which covers Association activities and initiatives in depth, and *Washington Highlights*, a weekly wrap-up of pertinent legislative and regulatory affairs.

In 1988, the Association's peer-reviewed *Journal of Medical Education* began its transformation into the journal *Academic Medicine*, expanding its portfolio to include major essays, opinion pieces, guest columns from national policymakers and even brief explorations of medicine in literature. The first issue appeared in January 1989, and later that year the journal published its first special supplement, the proceedings of a conference on medical education in ambulatory settings. In FY 93, *Academic Medicine* published a theme issue—an examination of the future of medical education and the legacy of Lowell T. Coggeshall, M.D.—and three special supplements.

Dr. Petersdorf has played an active role in developing these periodicals and has contributed regular columns to *Academic Medicine* and the *AAMC Reporter* since their inception.

Office of the General Counsel

The Office of the General Counsel coordinates the Association's legal representation and provides analysis and assistance to member institutions on legal issues that affect academic medicine. FY93 was a particularly active year

for this office. In *United States v. Brown University et al.*, the U.S. Department of Justice charged the eight Ivy League institutions and MIT with violating the Sherman Antitrust Act for their participation in an "overlap group" which sought to establish common principles under which financial aid would be given on a need-only basis. The schools' objective was to insure that limited financial aid resources were made available to those qualified applicants with the greatest need, but Justice argued they were restricting free trade.

The AAMC and 11 other not-for-profit educational associations filed an *amicus curiae* brief, arguing that Justice was misapplying the antitrust act, which, they maintained, was not intended to regulate charitable financial aid. The court ruled against the schools and the non-profit group filed a similar brief in an appeal, which still was pending at the end of FY93.

In *Platzer et al. v. Sloan-Kettering Institute for Cancer Research*, the relationship between researchers and their institution was challenged by three former employees who sued Sloan-Kettering for a sizeable chunk of the royalties from a licensed invention they helped develop. After losing the case in a lower court, the three appealed, and the Association filed an *amicus* brief in support of Sloan-Kettering. On Nov. 10, the U.S. Court of Appeals for the Federal Circuit affirmed the lower court's judgment in a ruling without accompanying opinion.

In *Katko v. The Ohio State University*, the actions of a resident following the instructions of the attending physician resulted in an adverse outcome for the patient. The trial court held that a resident could be held to the standard of care of a fully trained physician of ordinary skill, care and diligence.

The Appeals Court upheld the ruling, and the university appealed to the

Supreme Court of Ohio. In its *amicus* brief, the AAMC argued that the lower court ruling placed residents in an untenable position, by forcing them to second-guess the judgment of the attending physician, and would create chaos for graduate medical education. On February 3, the state Supreme Court dismissed the appeal as "having been improvidentially allowed." However, the Supreme Court ordered that "the court of appeals' opinion not be published in the *Ohio Official Reports*, and that it may not be cited as authority . . ." As such, although Ohio State lost the case, the Supreme Court ruling precludes its being used as precedent in future cases.

Last October, the AAMC and four other not-for-profit organizations filed suit against the Secretary of Health and Human Services in an attempt to overturn the five-year Reagan-Bush ban on federal funding of fetal tissue transplantation research. The suit contended that the secretary acted illegally in imposing the ban. The case was rendered moot in January when President Clinton signed an Executive Memorandum that lifted the ban.

In *Progressive Animal Welfare Society (PAWS) v. University of Washington*, the central issue is whether unfunded grant applications of public universities are subject to Washington (state) public disclosure law. The so-called "animal rights" group sought disclosure of an unfunded research grant application to study brain abnormalities in monkeys, with its stated purpose being to "block the issuance of public funds" for the grant.

The group sued the university, and the trial court ruled in PAWS' favor, ordering the university to release the grant application after the court excised those portions that it (the court) believed "reasonably necessary to protect . . . intellectual property rights as may now or hereafter exist." In an *amicus* brief

pending before the Supreme Court of the State of Washington, the AAMC and the American Council on Education argue that the "limited" disclosure ordered by the court, along with further budget information sought by PAWS on appeal, is inconsistent with federal and state laws and "threatens to harm university research." The appeal is pending.

Office of Administrative Services

The increased scope of AAMC programs and services during Dr. Petersdorf's tenure is reflected in the Association's new headquarters building, the people who work there and the diverse jobs they do. By 1993, the full-time staff numbered 230, with additional personnel brought in during peak medical school application season. In addition, the new building houses the National Resident Matching Program, which moved to Washington in July 1992, and the Office of Generalist Physician Programs, which opened this spring.

All of these people and programs are supported by the Office of Administrative Services. Within this division the Office of Information Services provides computer and telephone support, and this year is converting the AAMC to a local area network system and installing an electronic integrated financial accounting system. Administrative Services also oversees building maintenance and security, the print shop, publications and membership services. A four-person department of human resources attends to staffing and benefits matters. Visitors to AAMC headquarters cannot help but note the marked contrast to the operation of just two years ago, which had been forced by growth to separate into two buildings several blocks apart.

Office of Governmental Relations

The 1992 elections wrought some of the most dramatic changes seen in the federal government this century. In addition to the turnover of the White House, 120 new U.S. senators and representatives took office in January. Health care reform, ranked among the major issues in the 1992 campaign, may prove the critical factor in the nation's assessment of the Clinton administration's ability to govern.

Although the new president had not released his plan to rebuild the American health care system by the end of FY 93, Congress and several departments of the government already had begun to take action on a number of fronts to contain skyrocketing costs and address such issues as physician supply and care of the uninsured and underinsured.

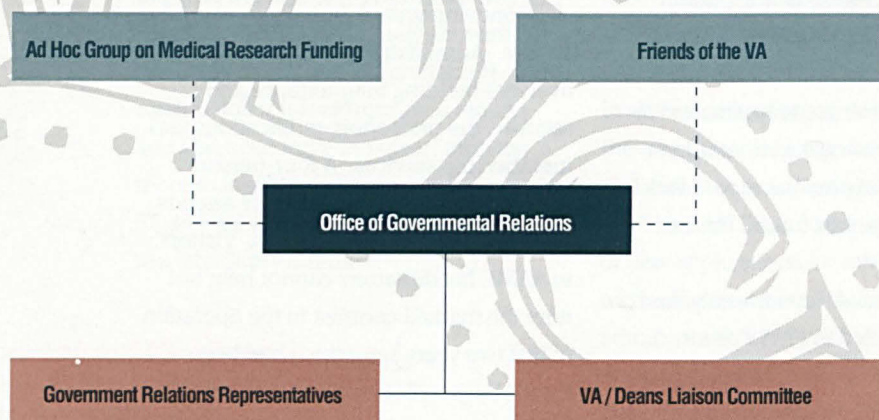
The AAMC Office of Governmental Relations monitors these and other federal legislative and regulatory affairs, working with constituents to provide data and expert testimony and, when necessary, marshalling institutional leaders to support or oppose measures that affect academic medicine.

Through this office, the AAMC participates in coalitions of organizations and individuals that advocate funding for veterans' health, biomedical research, Medicare and Medicaid, student financial aid and physician and hospital reimbursements for teaching and training.

An informed, active constituency is fundamental to the success of academic medicine's advocacy agenda. This was in evidence during Congress' consideration of the Omnibus Budget Reconciliation Act of 1993, which President Clinton signed into law on August 10. In a year when Congress exacted a five-year, nearly \$56 billion cut from projected spending in the Medicare program, the Association and its members were able to convince congressional leadership of the unique and necessary role of Medicare payments toward graduate medical education. As a result, the House-Senate budget conferees rejected an earlier Senate proposal to "weight" Medicare direct graduate medical education payments on the basis of specialty and retained the Medicare indirect medical education adjustment at its current rate of 7.7 percent for every 0.1 percent increase in the ratio of interns and residents to beds.

The Association's leadership also was instrumental in obtaining from the House increases over the administration's FY94 budget requests for medical research at the Department of Veterans Affairs and NIH. Although Senate action on these bills was pending at the end of FY93, it was clear that members of Congress had responded positively to the thousands of visits, telephone calls and letters from AAMC member institutions and faculty.

The medical programs of the Department of Veterans Affairs make up the largest single health care delivery system in the world. The VA health program has had affiliation agreements with U.S. medical schools since 1946, and many medical school graduates receive post-graduate training in its hospitals.



In recent years, the VA has faced increasing difficulty in obtaining sufficient funding to meet its health care and research missions. Independently and as part of a coalition, the Friends of VA Medical Care and Health Research, the AAMC works to ensure adequate funding for those programs. For FY94, the Friends of the VA recommended to Congress a total VA medical care appropriation of \$18.8 billion and a health research appropriation of \$312 million, significantly more than the \$15.6 billion medical care and \$206 million research appropriations submitted by the Clinton administration. AAMC constituents testified at hearings of the House and Senate committees that oversee the VA, arguing that the administration's recommended funding levels would have adverse effects on veterans' health at a time when the number of older veterans seeking care from the VA is increasing dramatically.

The House rejected the administration's research proposal and approved an FY94 VA research budget of \$252 million. By July 1993, more than 50 senators had signed a letter urging the Senate VA-HUD Appropriations Subcommittee to adopt at least the House's approved level for VA research.

The *Ad Hoc* Group for Medical Research Funding comprises more than 100 organizations that support increased National Institutes of Health funding. The AAMC was a co-founder of the group in 1982 and AAMC Senior Vice President Richard Knapp, Ph.D., is its current chair. Each year, the group develops and presents to Congress a budget proposal for NIH—a "bottom line" funding recommendation for all NIH programs. Rather than referring to specific institutes or categories of disease, the *ad hoc* group's proposal emphasizes the underlying principle that the whole of medical research, as embodied by NIH, is greater than the sum of its parts. Many

AAMC member institutions use the group's budget proposals in their own advocacy efforts on behalf of research funding.

Other important AAMC alliances include the Coalition for Health Funding, which advocates funding for the U.S. Public Health Service, and the Health Professions & Nursing Education Coalition.

The dearth of new physicians entering the generalist specialties has spawned several governmental initiatives aimed at encouraging primary care. In October 1992, an eleventh-hour House-Senate conference restructured several Title VII student financial aid programs, which formerly had been solely need-based, by incorporating a generalist service requirement. Student borrowers and scholarship recipients participating in these programs henceforth would be required to train and practice in a generalist specialty until they repay their loans or, in the case of scholarships, for five years. Failure to do so would activate severe financial penalties. The law also would penalize medical schools that fail to increase the percentage of their graduates choosing generalist practice by restricting their participation in the student aid programs.

Because the primary care language was added in House-Senate conference, the AAMC and other interested parties had no opportunity to comment on it. Although supporting Congress' intent, the Association opposed the measure because it appeared calculated to force needy students into primary care and would penalize medical schools for career choices made by their graduates, over whom the schools have little control.

In early February, staff of the Office of Governmental Relations and members of the Legislative-Regulatory Subcommittee of the Committee on Student Financial Assistance, an entity of the Group on Student Affairs, met with staff of more



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What we have witnessed . . . is a significant broadening of the interest of both state and federal government in an area in which it was hitherto quite limited.

Our unwillingness as the academic medical community to address the larger issues of manpower supply and specialty distribution, the limited effectiveness of our minority enhancement programs, and the ambiguity of our position on FMGs have invited governmental intervention. Government abhors a vacuum, and it rushes in where others fail to act.

We must either seize the initiative or be prepared to yield to lawmakers' and regulators' decisions that will shape the professions for years to come.

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Spencer Foreman, M.D.
AAMC Chair 1992-93

than 20 key Senate and House committee members. Two weeks later, a delegation of AAMC leaders, including Council of Deans Administrative Board member Herbert Pardes, M.D., and AAMC Chair-elect Stuart Bondurant, M.D., met with Energy and Commerce, Health and the Environment Subcommittee Chair Henry Waxman (D-Calif.) and the staffs of Rep. Bliley (R-Va.) and Sens. Kennedy (D-Mass.) and Kassebaum (R-Kan.) to advocate revision of the primary care measure.

Acting on the advice of the AAMC

delegation, the Executive Council voted to seek technical corrections to the law rather than calling for its repeal, which they said was extremely unlikely and which, if sought, could alienate valuable friends on the Hill.

On June 10, President Clinton signed S.1, the conference version of the mammoth NIH Revitalization Bill, which contained several corrections the AAMC had sought, including:

- deferring from 1994 to 1997 the first year for which a school's percentage of primary care graduates will determine

its eligibility to retain funds in the loan program,

- eliminating an "exceptional financial need" clause that would have restricted the primary care loans to the poorest students, and
- adding an appeal process for borrowers or scholarship recipients who believe they have justifiable reasons, such as exceptional financial hardship, for not completing the primary care requirement.

AAMC Testimony

1. Simplification of the Federal Family Education Loan Program. Presented by Norma E. Wagoner, Ph.D., Dean of Students, Pritzker School of Medicine, University of Chicago, to the Advisory Committee on Student Financial Assistance, October 16, 1992.

2. Comments on the Third Report of the Council on Graduate Medical Education, "Improving Access to Health Care Through Physician Workforce Reform." Presented by Robert G. Petersdorf, M.D., President, AAMC, at the Council on Graduate Medical Education, Rockville, Md., October 28, 1992.

3. Graduate Medical Education and Increasing the Supply of Generalist Physicians. Presented by Jordan J. Cohen, M.D., Dean, School of Medicine, State University of New York at Stony Brook, to the Physician Payment Review Commission, December 9, 1992.

4. National Institutes of Health Revitalization Amendments of 1993. Presented by Robert G. Petersdorf,

M.D., President, AAMC, to the House Energy and Commerce Subcommittee on Health and the Environment, February 3, 1993.

5. Role of the Department of Veterans Affairs in the National Health Care Delivery System. Presented by Donald E. Wilson, M.D., Dean, University of Maryland School of Medicine, before the Senate Committee on Veterans' Affairs, March 5, 1993.

6. FY 1994 Appropriations for the Department of Health and Human Services. Presented by Robert G. Petersdorf, M.D., President, AAMC, to the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, March 5, 1993.

7. FY 94 Appropriations for the Veterans Health Administration. Presented by Kim Goldenberg, M.D., Dean, Wright State University School of Medicine, before the House Committee on Veterans' Affairs, March 18, 1993.

8. The Impact of the Administration's Medicare Payment Proposals on Teaching Hospitals. Presented by Spencer Foreman, M.D., President, Montefiore Medical Center, and AAMC Chair, to the Subcommittee on Health, House Ways and Means Committee, March 18, 1993.

9. The Impact of the Administration's Medicare Payment Proposals on Teaching Hospitals. Presented by Spencer Foreman, M.D., President, Montefiore Medical Center and AAMC Chair, to the Senate Committee on Finance, April 1, 1993.

10. Role of the Department of Veterans Affairs in the National Health Care Delivery System. Presented by Gerard N. Burrow, M.D., Dean, Yale University School of Medicine, before the Subcommittee on Hospitals and Health Care, House Committee on Veterans' Affairs, April 28, 1993.

11. Comments on the Physician Payment Review Commission Recommendation to Restructure Graduate Medical Education. Presented by Robert M.

Dickler, Vice President, Division of Clinical Services, AAMC, to the Senate Special Committee on Aging and Rural Health Caucus, May 3, 1993.

12. Research Training in the Biomedical and Behavioral Sciences.

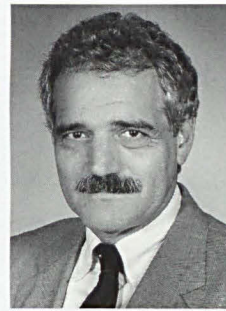
Presented by Thomas E. Malone, Ph.D., Vice President, Division of Biomedical Research, AAMC, to the National Research Council Committee on National Needs for Biomedical and Behavioral Research Personnel, May 3, 1993.



Norma E. Wagoner, Ph.D.
Pritzker School of Medicine
University of Chicago



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



Jordan J. Cohen, M.D.
School of Medicine
State University of New York
at Stony Brook

13. FY 94 Appropriations for the Veterans Health Administration.

Presented by Edward J. Stemmler, M.D., Executive Vice President, AAMC, to the Senate Subcommittee on VA-HUD-IA, House Committee on Appropriations, May 6, 1993.



Donald E. Wilson, M.D.
University of Maryland
School of Medicine



Kim Goldenberg, M.D.
Wright State University
School of Medicine



Spencer Foreman, M.D.
Montefiore Medical Center

14. Producing More Primary Care Physicians.

Presented by David M. Brown, M.D., Dean, University of Minnesota Medical School, to the Subcommittee on Medicare and Long-Term Care, Senate Committee on Finance, May 14, 1993.



Gerard N. Burrow, M.D.
Yale University
School of Medicine



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



William A. Peck, M.D.
School of Medicine
Washington University

15. University and Industry Collaboration: Technology Transfer Agreements.

Presented by William A. Peck, M.D., Executive Vice Chancellor for Medical Affairs and Dean of the School of Medicine, Washington University, to the Subcommittee on Regulation, Business Opportunities and Technology, House Committee on Small Business, June 17, 1993.

16. FY 94 Appropriations for the Department of Health and Human Services.

Submitted to the Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the Subcommittee on Appropriations, June 28, 1993.

Division of Medical Student and Resident Education

For the fifth consecutive year, the number of people applying to U.S. medical schools is on the rise. Although the final total will not be available until October, all indications at the June 30 close of the fiscal year were that the number of applicants will exceed the 1974 record of 42,621.

Among the approximately 16,000 people who enter medical school in fall

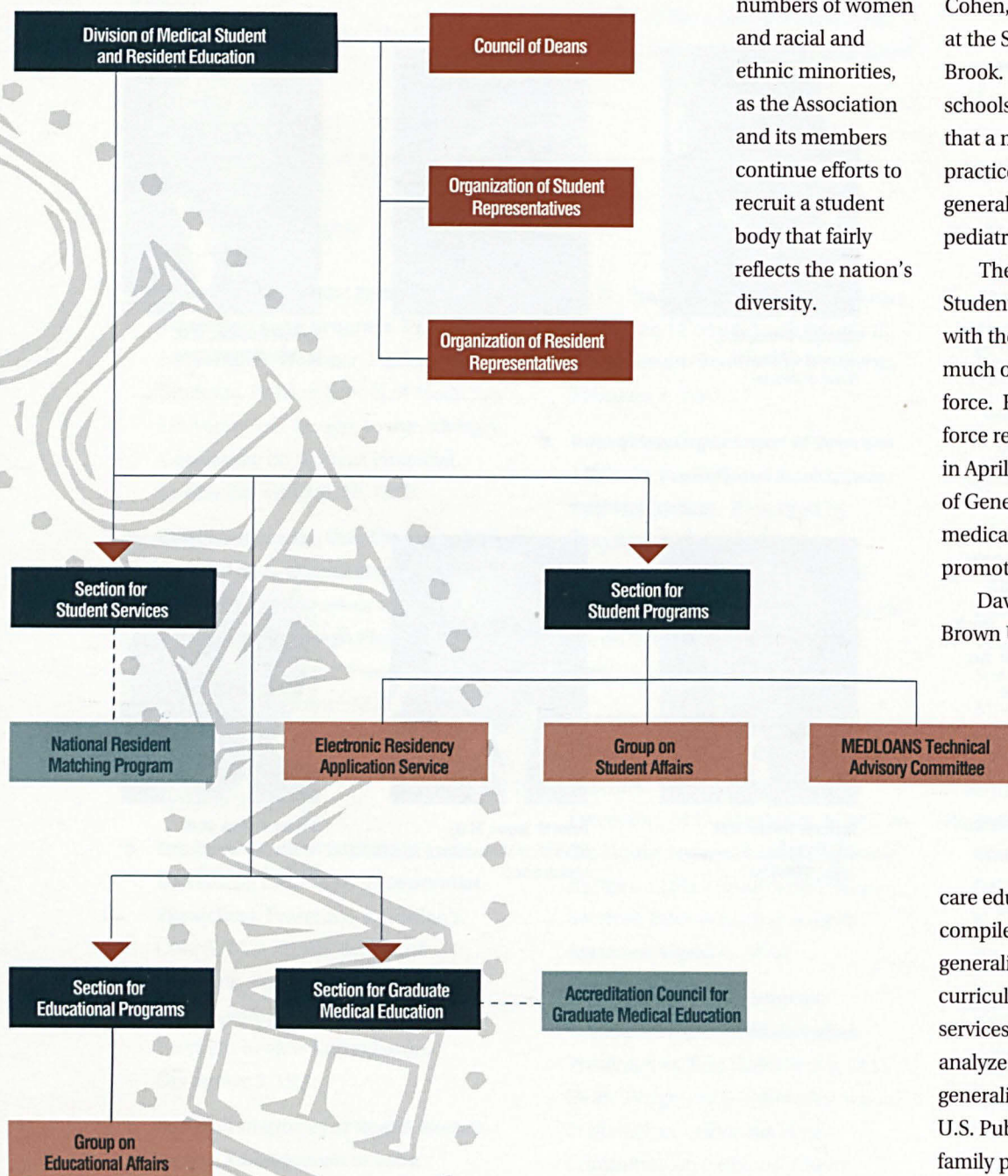
1993 will be greater-than-ever numbers of women and racial and ethnic minorities, as the Association and its members continue efforts to recruit a student body that fairly reflects the nation's diversity.

The new students likely will encounter curricula that place a much greater emphasis on primary care. The need for primary care or generalist doctors has become one of the major issues of health care reform. Many states have enacted or are attempting to enact laws to penalize state medical schools that fail to graduate more primary care doctors. In October, the Executive Council adopted as policy the report of the AAMC Generalist Physician Task Force, chaired by Jordan J. Cohen, M.D., dean of the medical school at the State University of New York-Stony Brook. The report called on medical schools to set an overall, national goal that a majority of their graduates enter practice in the generalist disciplines of general internal medicine, general pediatrics and family medicine.

The AAMC Division of Medical Student and Resident Education, along with the Office of the President, provided much of the staff support to the task force. Responding to a principal task force recommendation for AAMC action, in April the Association opened the Office of Generalist Physician Programs to help medical schools develop programs to promote primary care.

David Greer, M.D., dean *emeritus* of Brown University School of Medicine, is serving as acting director of the office while the search is under way for a permanent director. The office will function as a clearinghouse for information on primary

care education and training. Staff will compile data on schools' existing generalist programs in areas such as curriculum, financial aid and student services. They also will gather and analyze information on postgraduate generalist programs, working with the U.S. Public Health Service; national family practice, pediatrics and internal medicine organizations; and private



groups such as the Robert Wood Johnson Foundation, the Pew Charitable Trusts and the Kellogg Foundation. A national advisory committee representing medical schools and teaching hospitals will provide guidance from constituents.

The division provides direct staff support to the AAMC Council of Deans. The Section for Graduate Medical Education helps coordinate the Association's interaction with other groups concerned with the training, assessment and career development of medical school graduates. These include the Physician Payment Review Commission (PPRC), the Council on Graduate Medical Education (CoGME) and the Accreditation Council on Graduate Medical Education (ACGME). This section provides staffing for the AAMC Organization of Resident Representatives, which represents physicians-in-training in the AAMC governance.

Staff of the Section for Student Programs this year collaborated with staff of the Division of Institutional Planning and Development on developing one of the AAMC's newest and most exciting services, the Electronic Residency Application Service (further described in the section on the Division of Institutional Planning and Development). The section also provides staff support to the AAMC Organization of Student Representatives and Group on Student Affairs.

The Association continues to lead academic medicine in developing curricula that reflect such educational innovations as computer-assisted learning, ambulatory clinical training, problem-based learning, rural clerkships and the use of standardized patients. This division's Section for Educational Programs works with innovators in education to find new ways to promote effective communication between faculty and students and, ultimately, between doctors and patients.

In October 1992, the Association published *Educating Medical Students*, the report of the Charles E. Culpeper Foundation-funded "Assessing Change in Medical Education—The Road to Implementation" (ACME-TRI) project. The report documents schools' approaches to educational change, the barriers they have encountered and, most important, it offers strategies to help overcome these barriers. Staff of this section also provide support to the AAMC Group on Educational Affairs.

In December this division, along with staff of the Division of Educational Research and Assessment, organized the consensus conference "The Use of Standardized Patients in the Teaching and Evaluation of Clinical Skills." The conference was an early response to recommendations in the ACME-TRI report and was funded as part of the Culpeper Foundation's ACME-TRI grant. More than 185 educators, researchers and academic leaders attended the meeting and discussed ways to use these trained patient-surrogates to teach and evaluate students' skills in history-taking, patient interaction and physical examination.

The bumper crop of would-be physicians has tested the resources of admissions committees and others involved in the application and selection process, including the AAMC's American Medical College Application Service (AMCAS). During the peak application "season," the Section for Student Services added permanent and temporary staff and extended application processing hours, at times running two shifts, with senior staff routinely working nights and weekends.

FY93 also was the first year the National Resident Matching Program (NRMP) operated out of the Association's Washington headquarters. In 1993 the NRMP added matches in gynecologic oncology and primary care/sports medicine, bringing to 14 the number of NRMP specialty matches.



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If we are to meet our covenant with society . . . we must make significant and meaningful changes in the process of education, safeguarding the strong scientific orientation that has made us great while preparing physicians to deal with the problems of everyday practice. We must gather a more heterogeneous population of individuals into the cadre of physicians to meet the needs of the unserved and underserved.

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D. Kay Clawson, M.D.
AAMC Chair 1988-89

Division of Biomedical Research

With the nation's attention increasingly focused on the crises in health care delivery, there is danger that the biomedical research enterprise may suffer. The long-term benefits to society that medical research provides may be neglected in the rush to control costs and provide access to quality care. The AAMC believes that the resolution of the current health care dilemma should not obscure the goals of reducing the burdens of illness and disability and extending healthy life. Access to care is not enough to relieve the suffering of those with Alzheimer's, Parkinson's, AIDS, chronic mental illness or cancer. Only research offers hope for cures for these and a host of other ills.

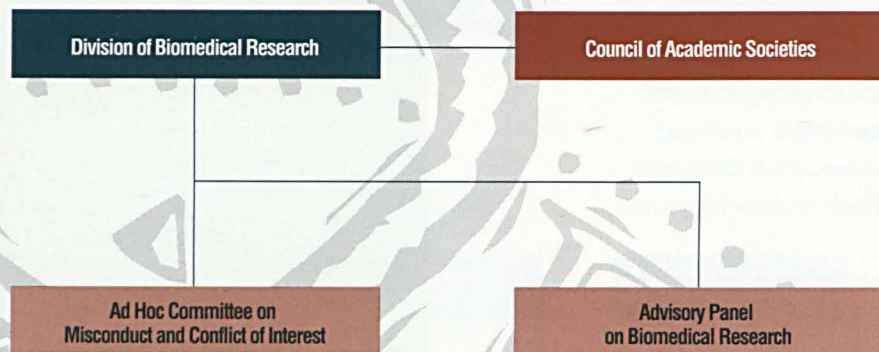
At current funding levels, many scientists and science policy experts maintain that society is missing critical research opportunities. In FY93, the National Institutes of Health funded an estimated 23 percent of submitted and competing research grant proposals.

Thus far, the situation for FY94 does not look much better. The administration's proposed appropriation for NIH reflected only a 3.2 percent increase over FY93, with significant funding "earmarked" for AIDS research, the women's health initiative, the minority health initiative,

breast cancer research and the human genome project. Although these are worthy initiatives, the overall toll on other, less directed research would be a \$230 million decrease in the remaining funds. The predicted success rate for new and competing grants still would fall below 22 percent (fewer than 6,000 awards) and the annual 4 percent cost-of-living increase on non-competing renewals would be eliminated. The AAMC has worked diligently to persuade Congress to restore both of these aspects of NIH funding to levels previously established by Congress and the NIH in a financial management plan.

The Division of Biomedical Research is the hub of the AAMC's activities on behalf of the research community. Staff work with constituents to define appropriate roles for the Association in shaping the laws, policies and regulations that affect biomedical research. This division directly supports the AAMC Council of Academic Societies, which represents medical school faculty among the Association's governance and comprises representatives from some 90 professional organizations of basic science and clinical disciplines. The CAS this year organized more formally its special interest groups on clinical research, basic research, graduate medical education and undergraduate medical education, which it established in 1991. And for the second year, a liaison committee with the AAMC Group on Educational Affairs has met to coordinate activities pertaining to undergraduate medical education.

This division also works closely with the Office of Governmental Relations and member institutions in their efforts to encourage Congress and the executive branch to pursue every opportunity to expand medical knowledge and technology. The division provides principal staff support to the AAMC Advisory Panel on Biomedical Research (APBR), a distinguished constituent group that gathers



and analyzes information on various aspects of biomedical research policy on behalf of the AAMC Executive Council.

This year, CAS Immediate Past Chair Kenneth I. Berns, M.D., Ph.D., chair of the department of Microbiology at Cornell University Medical College, succeeded David H. Cohen, Ph.D., provost of Northwestern University, as APBR chair. A panel subcommittee on advocacy has been establishing contacts with key congressional committee members and people in the Clinton administration with authority over research and health policy. A newly formed second subcommittee has begun exploring graduate research education and training. The panel also has provided analysis of the Biomedical Research and Development Price Index and has continued its work to ensure that academic institutions receive equitable reimbursements for the indirect costs of research projects.

This division works to promote the highest standards of research conduct and better relationships among scientists, their institutions, government and private industry. This year, the division concentrated heavily on fostering scientific integrity at both the institutional and the individual levels.

In April, the Association and NIH, together with an independent organization, Public Responsibility in Medicine and Research, sponsored a groundbreaking conference on teaching biomedical research ethics. The conference provided medical schools and other research institutions the opportunity to share their experiences in designing and implementing programs to meet government requirements that they instruct research trainees in the responsible conduct of research.

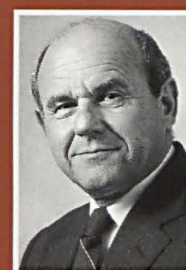
A second conference, "The Presence of Industry and Government in the Academic Setting: Benefits and Conflicts," is scheduled for December. This meeting will examine challenges emerg-

ing from the new role of industry in the longstanding partnership between government and academe in biomedical research. Participants will address such issues as commercialization of publicly funded research, institutional conflicts of interest and the clash of cultures that occurs when these three sectors come together.

Division staff also work with the AAMC *Ad Hoc* Committee on Misconduct and Conflict of Interest in Research to develop publications, meetings and other activities to promote responsible conduct in research. The committee, in conjunction with the American Association for the Advancement of Science (AAAS), will present a workshop on handling allegations of misconduct at the AAMC 1993 Annual Meeting.

In November, the Association published *Beyond the "Framework": Institutional Considerations in Managing Allegations of Misconduct in Research* to help institutions effectively deal with breaches of scientific integrity. This new volume is a companion to *Framework for Institutional Policies and Procedures To Deal with Misconduct in Research*, which the AAMC developed and published in 1988 in cooperation with an inter-association working group of interested organizations.

In December 1992, the AAMC co-sponsored with the AAAS a practicum on responding to allegations of research misconduct. The practicum, held in San Francisco, was led by two academic administrators and a university lawyer all experienced in managing cases of alleged research misconduct. This fall, the AAMC's *Teaching the Responsible Conduct of Research: A Case Study Approach*, will join the Association's catalog of publications on the topic.



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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.

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David H. Cohen, Ph.D.
AAMC Chair, 1989-90

Division of Clinical Services

In a year when health care increasingly has occupied the national agenda, the Division of Clinical Services, along with the Office of Governmental Relations, has been thrust to the vanguard of the AAMC's relations with the world outside academe. Leaders in medical education have noted with dismay the general lack of attention to education and training in most proposals offered as blueprints for a reformed health care delivery system. In a truly reformed delivery system—one that actually provides quality medical care for all Americans—a cadre of well-trained physicians will be more important than ever.

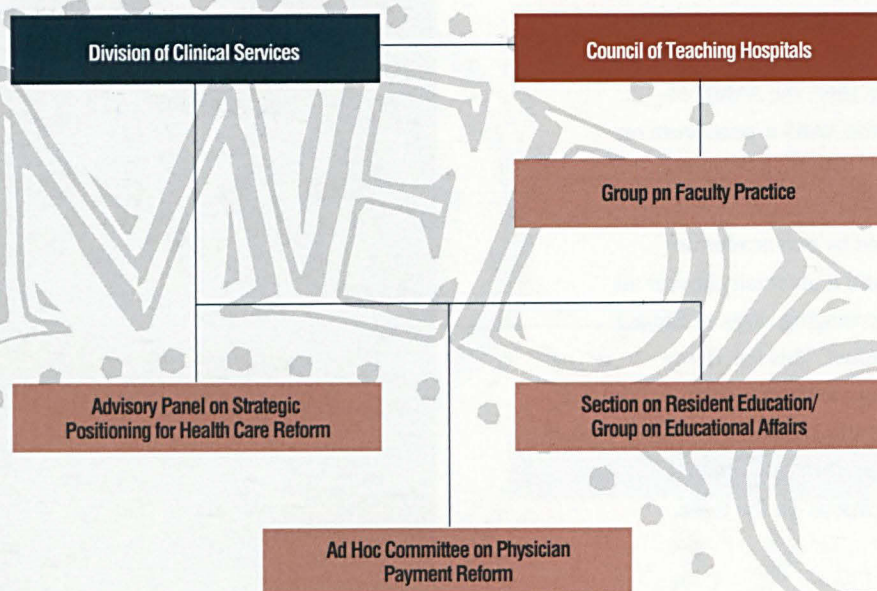
This division provides direct staff support to the AAMC Council of Teaching Hospitals (COTH). Staff work synergistically with the Office of Governmental Relations in areas that concern teaching hospitals, such as regulations affecting Medicare payments, physician and hospital payments, training residents and, to some extent, Medicaid activities. Through publications and data analyses, they support teaching hospitals, faculty practice plans and the physicians and

administrators involved in training residents. Staff also work with two AAMC constituent groups, the Section on Resident Education (SRE) and the Group on Faculty Practice (GFP). The SRE this year began a study of graduate medical education consortia, preliminary results of which were presented at the section's May meeting.

In recent years, medical schools and their faculties have come to rely increasingly on patient care revenues from affiliated teaching hospitals as sources of operating revenue. COTH member hospitals account for nearly two million Medicare discharges annually. The Medicare program designates payments to teaching hospitals to help pay for graduate medical education.

In March, the Prospective Payment Commission (ProPAC) recommended that Congress substantially reduce the indirect medical education reimbursement (IME)—a payment intended to compensate teaching hospitals for their higher costs due to the severity and complexity of illness among their patients. AAMC data indicate that teaching hospitals would be harmed by any reduction in the level of IME adjustment. Division staff worked closely with the AAMC Office of Governmental Relations to urge Congress to retain the original purpose of the IME adjustment—helping teaching institutions cover the costs of training physicians while caring for patients.

The financial burden of training expenses and other “unequal” costs has raised concerns that academic medical centers and teaching hospitals would be



hard-pressed to compete in a new health care system in which providers are chosen largely on the basis of cost. In mid-1992 the Association organized the Advisory Panel on Strategic Positioning for Health Care Reform, chaired by William Kerr, director, The Medical Center at the University of California, San Francisco, to draft AAMC recommendations on health care reform and help member institutions prepare to stay viable in what likely will be a dramatically changed health care environment. Many groups already had put forth proposals to redesign the health care system. Rather than create yet another, the Association directed its efforts specifically toward the academic missions of education, patient care and research.

Early this year, the advisory panel drafted its first position papers, including a statement of goals and principles for health care reform; papers addressing graduate medical education and health-related research; and *Academic Medicine, Cornerstone of the American Health Care System*, which underscores the essential roles of academic medicine's three missions—education, research and patient care—in the nation's health care system. After discussion by and contributions from the Association's governance councils, the papers were adopted as policy statements by the Executive Council at its June meeting.

The graduate medical education paper calls on Congress to create an "all-payer" fund to support GME and a National Physician Resources Commission to project the aggregate supply of doctors needed; set goals for the total number of residency positions and their distribution among the generalist (general internal medicine, general pediatrics and family medicine) and other specialties; review incentives to reinforce national goals; and provide a link for workforce planning for physicians and

other health professionals.

The paper on health-related research urges Congress and other policy makers to maintain financial support for biomedical, clinical and behavioral research. It states that health services research—which examines the organization, financing, delivery and outcomes of health care—should be funded separately from biomedical research because of its critical role in health care reform.

The advisory panel will continue to examine the myriad issues that will affect academic medicine in the new health care delivery system—issues that academic medical institutions must confront internally as well as those that affect their external relationships. Among the latter, they will pay particular attention to the role of the Department of Veterans Affairs health care system in medical education.

This division also provides principal support to the AAMC *Ad Hoc* Committee on Physician Payment Reform, chaired by Michael E. Johns, M.D., dean, The Johns Hopkins University School of Medicine. The committee members began meeting this spring to discuss the Physician Payment Review Commission's (PPRC) 1993 Report to Congress and to draft AAMC policy statements on physician reimbursement.

Their work was lent urgency by a May announcement by the Health Care Financing Administration's Office of Physician Payment Policy that changes were occurring in the rules regarding reimbursement for attending physicians. As proposed, the new rules could severely restrict teaching hospitals' abilities to support the training of young doctors. Division staff will work with colleagues in the Office of Governmental Relations to achieve modifications to the regulations to lessen their negative effects on the educational mission of academic medical centers and other training sites.



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A credible response to society's current needs and expectations can best be undertaken by establishing a national agenda in academic medicine that places a high priority on health services research and the scientific analysis of our entire health care system.

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John W. Colloton
AAMC Chair 1987-88

Division of Minority Health, Education and Prevention

Project 3000 by 2000, the AAMC initiative to increase to 3,000 the number of underrepresented minority students annually matriculating at U.S. medical schools by the year 2000, was in its second year of implementation in FY93. Last fall, when the Association tallied final application, acceptance and matriculation figures for the entering class, there were indications that the project already was having a positive effect on minority enrollment. The number of underrepresented minority (URM) applicants (blacks, Mexican Americans, Mainland Puerto Ricans and American Indians/Alaskan natives) rose to 4,034, an all-time high. The 1,827 under-represented minority new entrants, composing 11.2 percent of all new entrants, also represent a record high. Overall minority matriculation was 15.3 percent greater than the prior year.

The increase over the prior year among all male URM matriculants was 9.6 percent and URM women increased by 20.4 percent. The percentage of black male matriculants increased substantially, with 6.6 percent more entering medical school than did in 1991, despite a slight decrease in the number of accepted black male applicants. The scarcity of young black men entering higher education in recent years has been a well-chronicled societal concern. This spring, the number of black applicants for the class that will enter in fall 1993 began to show a marked increase, with black men showing a greater increase than black women for the first time in 12 years.

The growth in numbers of minority applicants and matriculants is a positive sign that the near-term strategies of *Project 3000 by 2000*—increasing the number of qualified minority undergraduates that apply to medical schools and the percentage of accepted applicants who matriculate—are working. But medical schools already attract a disproportionately large share of qualified undergraduates. If the project is to achieve its longer-term goal and, ultimately, if medical schools are to achieve proportional representation of underrepresented minorities, then the pool of URM students who have the academic preparation needed to enter and complete medical school must be much larger.

Achieving this will require a massive, cooperative effort by medical schools; undergraduate schools; local school officials; minority physicians; and church, community and civic leaders. The ultimate mission of the project is to enhance significantly the quality of the educational experience available to minority students in the nation.

Last fall, staff of the Division of Minority Health, Education and Prevention organized five regional meetings to acquaint medical school deans with the magnitude of the project and their roles therein. Faculty at the meetings included educators and administrators from all stages of the educational pipeline who are involved in successful minority enrichment programs. More than 80 deans attended the meetings and, by spring, all U.S. medical school deans had appointed project coordinators to spearhead programs at their schools. This summer, the initiative pushed forward with division staff holding the first three in a series of five regional technical assistance workshops to help medical school, college and high school educators set up health-science partnerships.

Division of Minority Health,
Education and Prevention

Minority Affairs Section /
Group on Student Affairs

Project 3000 x 2000
Executive Implementation Committee

Through this division, the AAMC also addresses the needs of minority students, physicians and faculty. The AAMC Health Services Research Institute, funded by a grant from the Agency for Health Care Policy and Research (AHCPR), sponsored a number of activities to increase research opportunities for minority faculty.

Last year, the advisory committee for "Minority Capacity Building in Health Services Research" selected 25 fellows to take part in the AAMC institute's programs. In April, the fellows took part in mock study section exercises in which they participated in the rigorous review process their research proposals will undergo at AHCPR, NIH and other funding agencies. In June, four of the AAMC fellows gave poster presentations at the annual meeting of the Association for Health Services Research. By the time the institute holds its closing meeting in September, the fellows will have completed nearly two years of intensive training in all aspects of research—from concept and design through funding to publication.

In December, more than 200 people gathered to examine factors affecting the health and health care of the nation's minority populations at the AAMC-sponsored conference "The Role of Race, Class and Ethnicity in Health Services Research." This year, the division will begin a three-year project to create a database containing information on all U.S. minority physicians, which will be used for health services research. The division also will become the National Program Office for the Robert Wood Johnson Foundation's Minority Medical Education Program.

Cultural diversity sometimes creates unseen barriers to minority participation, even in institutions trying to remove those barriers. This year, division staff will update the 20-year-old Simulated Minority Admissions Exercise, which is

designed to sensitize medical school admissions personnel to cultural variables and non-cognitive qualities, such as leadership skills and a personal commitment to medicine, that they should consider when evaluating minority applicants. In October, the division will staff the fourth annual professional development seminar to help minority faculty develop skills they will need to advance through the academic ranks.

This division also provides staff support to the Minority Affairs Section of the Group on Educational Affairs (GSA-MAS). The AAMC Executive Council established the GSA-MAS in 1976 to

- advise the Association on issues related to minorities;
- provide a forum for minority constituents to express their views;
- assist in developing and implementing strategies and methods to enhance the recruitment, enrollment, retention and postgraduate training of minority medical students; and
- provide an official interchange for minority educators, administrators and others concerned with these issues within the AAMC.

At the 1992 AAMC Annual Meeting, GSA-MAS representatives hosted a briefing session for more than 500 New Orleans-area high school students interested in medical careers. The section also works with the division on implementation of *Project 3000 by 2000*, and some minority affairs officers also are project coordinators at their institutions. Next January, the Association will offer the first Minority Affairs Professional Development Conference for medical school administrators in admissions, financial aid and student affairs and others whose work encompasses minority affairs.



“The seasons of the past year have propelled medicine to the center of public attention in the United States and throughout the world. As we enter this new season . . . of public accountability, our challenge is to accept social responsibility.”

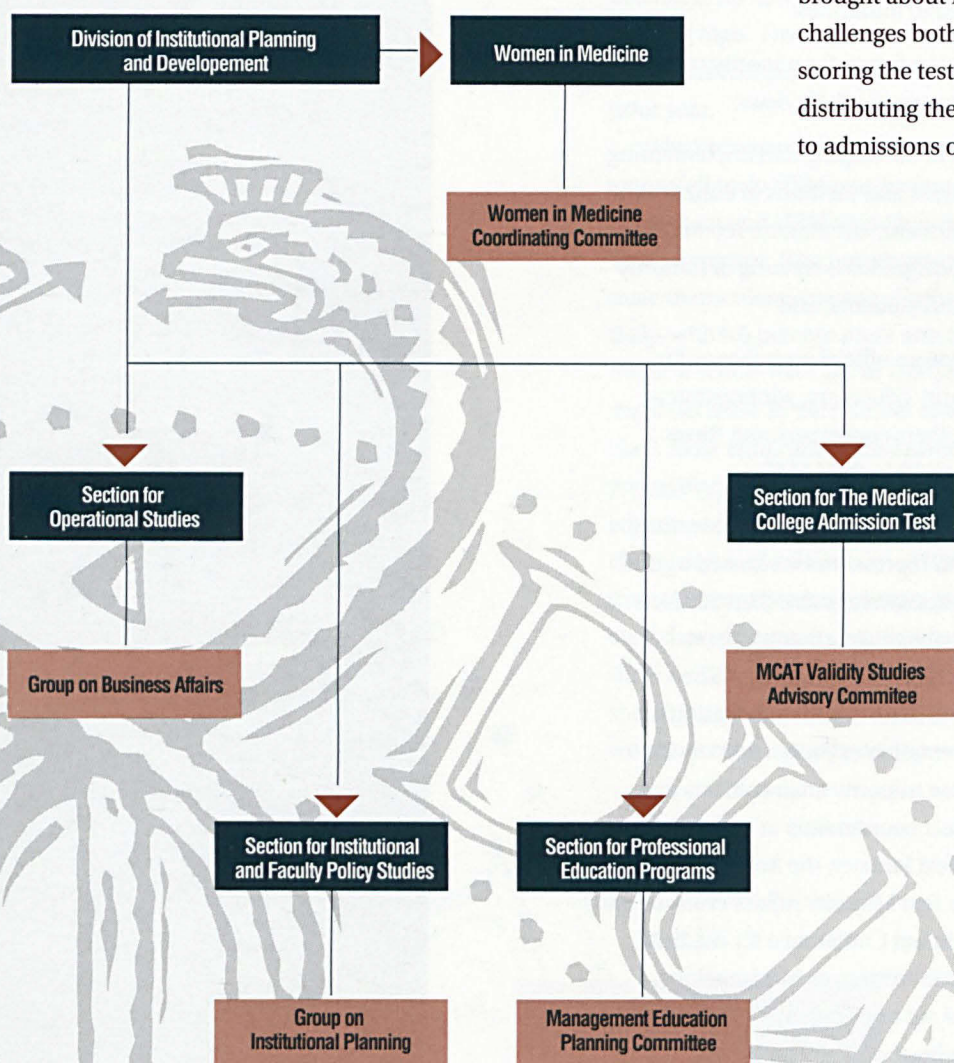
William T. Butler, M.D.
AAMC Chair 1990-91

Division of Institutional Planning and Development

As academic medical institutions have evolved in scope and complexity, so have AAMC programs to support those institutions. The Division of Institutional Planning and Development offers assistance to member institutions through a diverse array of professional development programs, workshops, training, publications and data gathering and analysis.

This division is the point of entry for would-be medical students through its management of the Medical College Admission Test (MCAT). Three years ago the test was revised to place greater emphasis on examinees' verbal reasoning and writing skills. The addition of two

essay questions brought about new challenges both in scoring the tests and distributing the scores to admissions offices.



The numbers of people taking the MCAT exam, administered twice per year, have been increasing dramatically. Admissions officers were faced with locating the essays of applicants in whom they were interested among thousands of other essays. The sheer volume of paper became cumbersome. At the 1992 Annual Meeting, the AAMC introduced a prototype of the MCAT Writing Sample Delivery System (WSDS) currently being tested in a 12-school pilot study. Ultimately, the WSDS will convey the essays of all applicants to admissions officers on CD-ROM.

Eventually, every medical school admissions office will be able to locate any of its applicants' MCAT essays on its own computer terminal, and, using PC-based software, view the essays on-screen or print them out. The Section for the MCAT also added a full-time director for test security to ensure the integrity of the testing process.

This division, in cooperation with the Division of Medical Student and Resident Education and an advisory committee chaired by Dartmouth Medical School Dean Andrew G. Wallace, M.D., also is applying information technology to the departure from medical school. In spring 1993, the Association announced the development of the prototype Electronic Residency Application Service (ERAS), which will be capable of transmitting all application materials, including dean's letter and transcripts, from a PC terminal in the dean's office to program directors at teaching hospitals and other post-graduate training sites.

In FY93, women made up nearly 40 percent of U.S. medical school enrollments, continuing a steady trend toward proportional representation. Several schools reported that more than 50 percent of first-year students were women, and at least one school graduated more women than men in the class of '93. The numbers and percentage of

women on medical school faculties also have grown, but that growth largely has been confined to the lower ranks. This year 5 of the 126 deans of medicine and 92 medical school department chairs were women.

The Association's Women in Medicine program provides support, information and networking opportunities to both faculty and student women. An annual professional development seminar for junior women faculty has consistently been oversubscribed. This year, the first such meeting for Senior Women in Medicine marked a milestone in that there are sufficient numbers of women in such positions to warrant a separate seminar. Another sign of progress in this area was the publication of the second edition of *Building a Stronger Women's Program*, which has swelled to 100 pages from the 1990 edition's 13.

Medical schools have been under increasing pressure from state and federal governments to increase the numbers of graduates entering generalist practice. In converting the former Health Professions Student Loans to the Primary Care Student Loans, Congress set targets for medical schools to improve their generalist output by a specific percentage each year until 50 percent of their graduates choose generalist careers. In order to keep participating in the financial aid program, schools must be able to track the careers of their graduates. To help them do so, staff of this division's Section for Operational Studies have generated school-specific reports that list the post-graduate training activities of each graduate from the classes of 1987 through 1989.

Current economic conditions and impending health care reform have intensified the need for ready access to comparative medical school financial and programmatic data. The Section for Operational Studies enhanced the Institutional Profile System (IPS) so it can

produce reports on medical schools' relative status based on data collected by the AAMC and the Liaison Committee on Medical Education.

This Section also produces the *Report on Medical School Faculty Salaries*, which tracks 52,000 full-time faculty by department and rank. The Faculty Roster System, the most comprehensive source of information on the faculties of U.S. medical schools, was the resource for some major publications, including *The Participation of Women and Minorities on U.S. Medical School Faculties, U.S. Medical School Faculty 1992. FRS Alumni Reports* allow AAMC constituents to locate M.D., Ph.D., and clinical training alumni who are full time faculty at U.S. medical schools. Section staff also provide support to the AAMC Group on Business Affairs.

To help member institutions adjust to the end of mandatory retirement, the Section for Institutional and Faculty Policy Studies published a study of early retirement incentive programs and currently is undertaking a comprehensive survey of how medical schools appoint and promote faculty. The section provides staff support to the AAMC Group on Institutional Planning.

The Section for Professional Education Programs spearheads the AAMC Management Education Program (MEP) for leaders in academic medicine. The last day of FY-93 was the opening day of the newest MEP seminar, "Getting From Here to There: Developing a Strategy to Enhance the Primary Care/Generalist Experience in Undergraduate Medical Education." Like some other MEP programs, the generalist workshop was designed for institutional teams, rather than individuals, to take a practical approach to planning a generalist curriculum.



“

It is important to consider the response of medical education to society's expectations as the response of an integrated system and not as a series of independent bidimensional issues. For the multiple dimension of education and medical practice are interactive, sometimes in surprising ways.

”

Stuart Bondurant, M.D.
AAMC Chair-elect, 1993-94

Division of Educational Research and Assessment

Addressing the problems of physician specialty and geographic maldistribution has been a common thread linking much of the Association's activities in the past year. Educators and others concerned with physician supply acknowledge that too few medical school graduates are choosing to practice as generalists or in rural and urban underserved areas. The Division of Educational Research and Assessment, formed during Dr. Petersdorf's early-1992 reorganization of the Association's staff structure, gathers and analyzes much of the data used to gauge the origins and extent of the problems and, most importantly, to identify possible solutions.

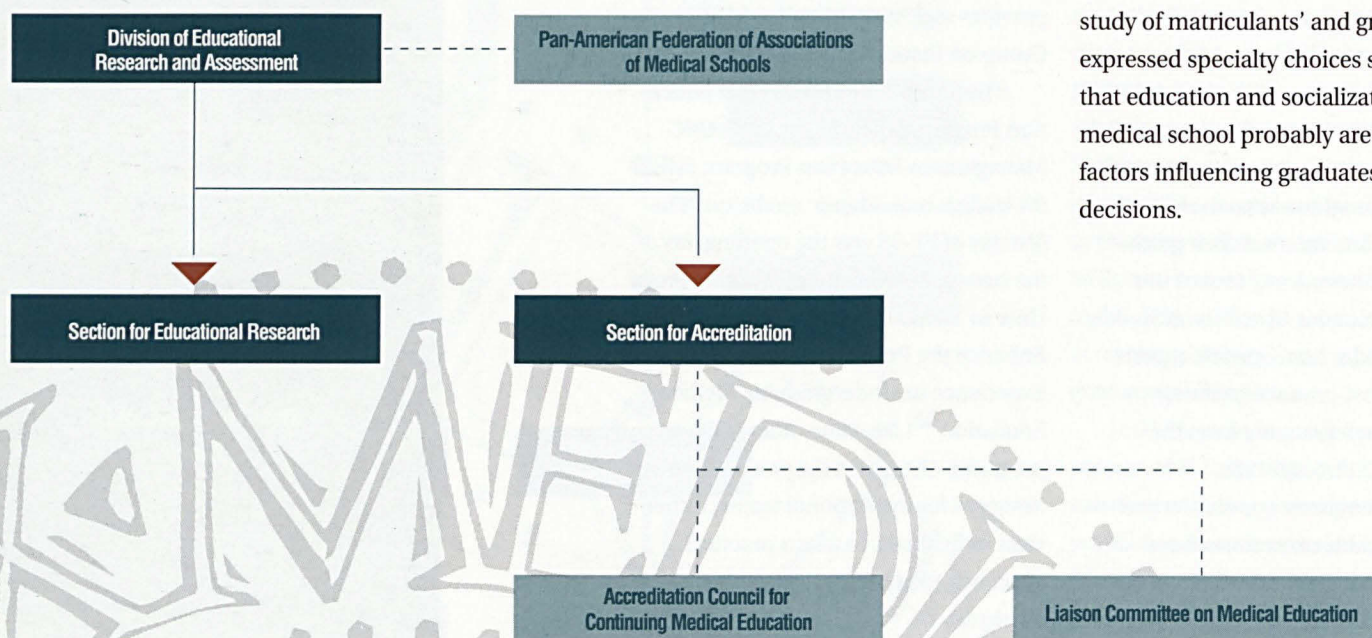
One of the first major projects of the Section for Educational Research was refining the student questionnaires to insure timely, accurate collection of data on applicant, student and graduate attitudes toward medicine; educational experiences; and factors influencing career and practice choices. Section staff also recalculated data from prior years to

provide a consistent database extending back more than a decade.

The new information is critical to the Association's generalist, rural health and health care reform goals. In 1982, more than 36 percent of the graduates said that they would seek certification in general internal medicine, general pediatrics or family medicine and not subspecialize. By 1992, that percentage had fallen to less than 15. However, the tide of interest may have turned in 1993, when more than 19 percent of graduating seniors indicated plans for a generalist career.

During the past year, section staff examined a number of factors influencing the specialty choice of medical school graduates and published the results in *Academic Medicine*. "Specialty Preferences of Graduating Medical Students: 1992 Update" discussed the revisions to the graduation questionnaire and the decline in interest in primary care.

"On the Relationship between Indebtedness and the Specialty Choice of Graduating Medical Students" found that educational debt related only slightly to graduates' increasing preference for non-generalist specialties. A later comparison study of matriculants' and graduates' expressed specialty choices suggested that education and socialization during medical school probably are stronger factors influencing graduates' career decisions.



"Rural Sources of Medical Students, and Graduates' Choice of Rural Practice" confirmed that students with rural ties are more likely than those from non-rural areas to practice in rural settings.

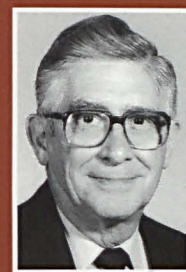
However, there simply are not enough students from such areas to provide sufficient numbers of doctors for rural America. Because rural practitioners are likely to be generalists (mostly family practitioners), graduating generalists is just as important as drawing students from rural areas to a medical school's ability to supply rural physicians.

This year, the division published *Trends Plus: U.S. Medical School Applicants, Matriculants, Graduates 1992*, a collection of data analyses providing a broad view of undergraduate medical education and the interrelationships between student characteristics and the selection process; the academic progress of students; and their specialty, career and practice intentions.

The division's Section for Accreditation is responsible for the Association's activities to insure the quality of undergraduate medical education. This year, the AAMC was principal secretariat for the Liaison Committee on Medical Education (LCME), the accrediting body for U.S. and Canadian medical schools. The Association sponsors the LCME jointly with the American Medical Association, and the two organizations alternate years as principal secretariat.

In the past year, the LCME conducted site visits to 30 U.S. and Canadian schools. The committee proposed new and amended accreditation standards, which were approved by the AAMC and AMA governing councils. The most noteworthy of these was a new standard requiring all medical schools to offer a core curriculum in primary care.

The Section for Accreditation also coordinates AAMC participation in the Accreditation Council for Continuing Medical Education. In September, the Association published *Guidelines for Faculty Participation in Commercially Sponsored Continuing Medical Education* to considerable acclaim from the academic, government and private sectors. For the first time, faculty and administrators have a framework for ethical conduct in their relations with commercial supporters. More important, other CME principals, such as the pharmaceutical industry, have boundaries of conduct that are demarcated clearly to prevent participants from straying outside legal and ethical limits. The document was the product of a cooperative effort among the AAMC *Ad Hoc* Committee on Misconduct and Conflict of Interest in Research, the AAMC Subcommittee on Conflict of Interest in Continuing Medical Education (both chaired by Joe D. Coulter, Ph.D., professor of Anatomy, University of Iowa College of Medicine) and staff of this division and the divisions of Biomedical Research, Institutional Planning and Development, Medical Student and Resident Education, and the Office of the President.



“

Medical education must strive to improve the scholarly nature of its programs and avoid the present trend toward practical and pragmatic learning. There is evidence that we are caught on a treadmill and moving toward vocationalism. If medicine is to remain a scholarly profession, the schools and teaching hospitals must emphasize scholarship in their programs.

”

Edward J. Stemmler, M.D.
AAMC Chair 1986-87

Division of Communications

As the nation's awareness of and dissatisfaction with the health care system has grown, so, increasingly, has its scrutiny of academic medicine. Questions that arise in policy circles frequently lead to inquiries from the media. Are medical schools training the kinds of doctors the nation needs? Are students taught about the special needs of women, minority populations, the elderly? Do today's medical school graduates have sufficient knowledge of pharmacology and nutrition? Can they recognize symptoms of substance abuse or domestic violence?

The academic medical community also needs more information on such topics as educational innovations, medical informatics, available research and career opportunities and how to promote generalism in the curriculum. And prospective medical students need to know which schools are best suited to train them for the types of medical careers they seek and which are most likely to accept their applications.

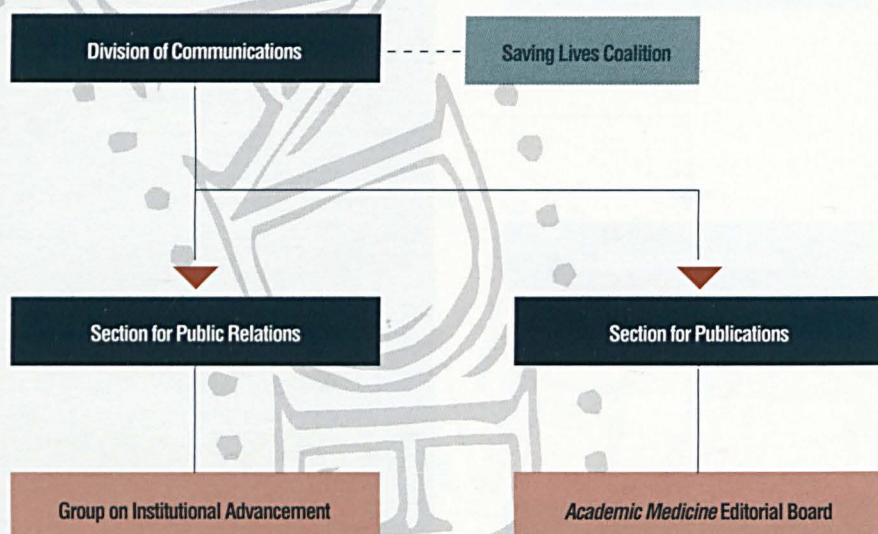
The AAMC Division of Communications provides a wealth of information for and about academic medicine—to the outside world through the media, and to the members and future members of the academic community through a variety of publications.

The Section for Public Relations facilitates interaction among the media, the Association and frequently, AAMC constituents. Section staff provide reporters and editors with information about AAMC initiatives and programs and, when appropriate, set up interviews with constituents or senior staff. The Association is known among journalists as the preeminent source of data on medical education, and staff respond to an average of more than 30 press inquiries per week.

This year, the section actively publicized the Association's position on the need for more generalist physicians, distributing hundreds of copies of the AAMC paper on the topic and setting up numerous interviews. In support of *Project 3000 by 2000*, section staff wrote three "print ready" news features about underrepresented minority group members participating in various stages of medicine—medical school, research and practice. The stories were distributed to minority-owned newspapers, which continue to use them.

The Section for Publications publishes the Association's peer-reviewed journal, *Academic Medicine*. Now in its 68th year, the journal is the premier venue for publishing essays and research in medical education. Strong peer-review is essential to ensuring that the journal publishes the highest quality of research, and this year, the journal expanded its complement of reviewers to more than 500 specialists in all areas of academic medicine and health policy.

Academic Medicine also publishes theme issues, special supplements and conference proceedings. In 1993, the



journal published a record four supplements and a theme issue. These included the proceedings of last year's consensus conference on the use of standardized patients in training and evaluation; a specially commissioned collection of 18 papers on integrity in biomedical research; and the peer-reviewed papers selected for the Research in Medical Education colloquium, held each year in conjunction with the AAMC Annual Meeting. Section staff continue to expand the journal's subscriber base through direct mail promotions.

This section also annually produces the *Directory of American Medical Education*, the *Curriculum Directory* and *Medical School Admission Requirements*. These directories provide detailed information available nowhere else and hence are valuable resources to constituents, medical school applicants and others.

For four years, the Section for Public Relations has been the focal point for the AAMC's leadership of the Saving Lives Coalition, an alliance of more than 350 scientific, medical, education and voluntary health organizations united in their support of the responsible use of animals in biomedical and behavioral research. The coalition serves as an information clearinghouse for and about such research. It provides research facilities with technical assistance in such areas as security and regulatory compliance and keeps them informed of the problems other institutions encounter and the solutions to those problems.

Equally important, the Saving Lives Coalition allows its diverse constituency to speak with one voice to Congress and the American people about how the products of animal research can improve and even save the lives of millions. In March, the coalition hosted a reception in the Rayburn House Office Building for new members of Congress, the third such event in as many years. A record number

of members of Congress and their staff braved a torrential downpour to attend the reception.

Rep. Rosa DeLauro, D-Conn., spoke movingly of her battle with ovarian cancer, saying, "It is not an exaggeration. My life was saved by important cancer research." National Institute of Mental Health Director Frederick Goodwin, M.D., a longtime supporter of the coalition and of animal research, introduced his friend, Academy Award-winning actor Rod Steiger, praising him for his courage in "speaking out, as one who has been afflicted." Mr. Steiger spoke of his struggle with acute clinical depression and of the drugs that helped him recover. "I am alive today, mentally, because of animals," he said.

This section also provides staff support to the AAMC Group on Institutional Advancement, the affinity organization for public relations, development and alumni professionals at AAMC member institutions. Formerly known as the Group on Public Affairs, the group changed its name this year to reflect better its broadened constituency.

In 1992, the AAMC became co-publisher of *Academic Physician*, a bimonthly newsletter that lists available faculty positions at academic medical institutions and carries news of AAMC activities and programs. It currently is distributed to all U.S. medical school physician faculty members. In FY94, *Academic Physician* will expand its listings to include non-physician faculty positions and non-faculty administrators under the new name *Academic Physician and Scientist*.



Every area in which medical school faculty are interested is subject to pressures and it is our responsibility to respond to pressures effectively. The best vehicle, outside our own academic disciplines, is through the effective organization of the AAMC. . . . We need to be able to deliver a clear and coherent message to the public and government decision-makers in Washington . . .

Kenneth I. Berns, M.D., Ph.D.
AAMC Chair-elect 1994-95

Report of the Treasurer

For the Fiscal Year Ended June 30, 1993

Fiscal Year 1993 was another satisfying period marked by the continuance of financial growth and positive operating performance.

Highlights

- As of June 30, 1993, the Association's total of unrestricted fund balances increased by almost \$1 million to \$26,658,000.
- During the year, the market value of investments grew to \$34,634,000, representing an increase of over \$2.6 million since June 30, 1992.
- The Association ended the fiscal year with a \$848,000 surplus of unrestricted operating revenue over expenses and transfers.

Operating Results

Unrestricted revenue from current operations increased from a year earlier by \$3,177,000, or almost 12% to \$29,759,000.

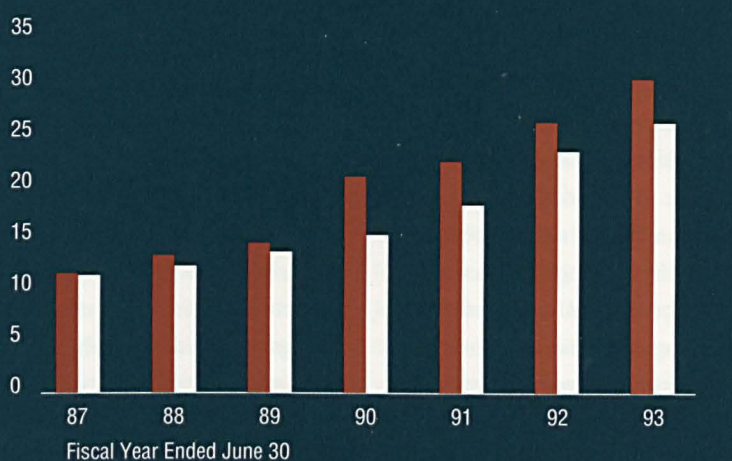
The significant rise in income is due to the continuing increase in applicants taking the Medical College Admission Test and using the Association's medical school application processing service.

Operating expenses increased by \$1,797,000, or approximately 8.3% to \$23,507,000. The magnitude of expenditure growth is attributed, in part, to the strengthening of the Association's professional staff.

The balance sheet and statement of revenue, expenses and changes in fund balances were extracted from the Association's audited financial statements.

Revenue, Expenses and Debt Service

(Millions of dollars)



Balance Sheet

June 30, 1993

Assets

Current Funds:

Cash and cash equivalents	\$ 5,030,613
U.S. Government contracts receivable	406,551
Accounts receivable - net	1,198,172
Investments (book value)	32,119,674
Supplies, deposits and prepaid expenses	340,427
Total current funds	\$ 39,095,437

Plant funds:

Investment in plant:	
Land	\$ 11,001,742
Building	19,670,740
Furniture and equipment	7,528,834
	38,201,316
Less accumulated depreciation	(3,766,036)
Total net investment in plant	34,435,280
Due from current funds	10,622,789
Other assets	606,286
Total plant funds	\$ 45,664,355

Liabilities and Fund Balances

Current Funds:

Accounts payable and accrued expenses	\$ 2,085,770
Custodial funds	1,086,101
Due to plant funds	10,622,789
Deferred revenue	6,366,842
Deferred compensation	1,821,454
Total liabilities	21,982,956

Fund balances:

Unrestricted	12,979,084
Designated	4,025,200
Restricted	108,197
Total current fund balances	17,112,481
Total current funds	\$ 39,095,437

Plant funds:

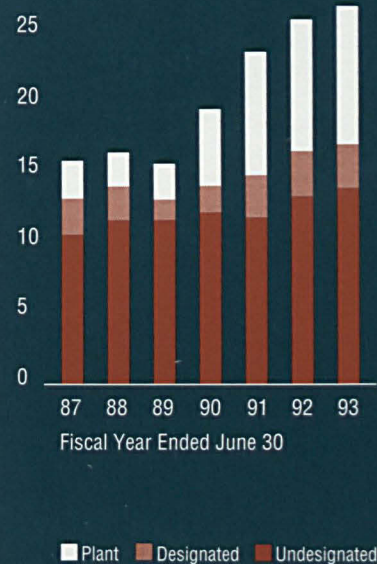
Accrued Interest expense	\$ 929,569
Bonds payable, net	33,721,989
Total liabilities	34,651,558

Fund balances:

Investment in plant	1,358,776
Unexpended - unrestricted	9,654,021
Total plant fund balances	11,012,797
Total plant funds	\$ 45,664,355

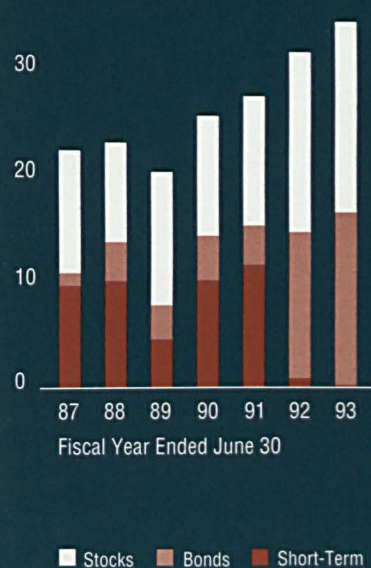
Unrestricted Fund Balances

(Millions of dollars)



Investments - Market Value

(Millions of dollars)



Statement of Revenue, Expenses, and Changes in Fund Balances

For the year ended June 30, 1993

	Current Funds					
	Unrestricted	Unrestricted Designated	Restricted	Total Current Funds	Plant Funds	Total Funds
Revenue:						
Dues	\$ 8,932,426	\$ —	\$ —	\$ 8,932,426	\$ —	\$ 8,932,426
Service programs	16,452,182	—	—	16,452,182	—	16,452,182
Journal of Academic Medicine	246,950	—	—	246,950	—	246,950
Other publications	1,025,685	—	—	1,025,685	—	1,025,685
Investment income	1,026,118	—	—	1,026,118	—	1,026,118
Private grants, net of refunds	7,828	—	239,084	246,912	—	246,912
Government contracts and grants	88,787	—	738,612	827,399	—	827,399
Meetings and workshops	692,447	914,567	—	1,607,014	—	1,607,014
Other	1,286,233	39,463	—	1,325,696	—	1,325,696
Total revenues	29,758,656	954,030	977,696	31,690,382	—	31,690,382
Expenses:						
Division administration and programs:						
Institutional planning and development	2,371,349	612,778	334,274	3,318,401	—	3,318,401
Governmental relations	773,444	26,023	—	799,467	—	799,467
Biomedical research	804,132	—	5,638	809,770	—	809,770
Medical student and resident education	4,810,580	86,867	157,292	5,054,739	—	5,054,739
Minority health, education and prevention	453,119	—	562,015	1,015,134	—	1,015,134
Clinical services	1,101,395	54,838	—	1,156,233	—	1,156,233
Communications	473,303	—	—	473,303	—	473,303
Publications	1,124,751	—	—	1,124,751	—	1,124,751
Educational research and assessment	287,568	—	(33,706)	253,862	—	253,862
Sub-council organizations	388,391	248,796	—	637,187	—	637,187
Liaison committees	253,190	—	—	253,190	—	253,190
Special studies	2,463,046	89,599	—	2,552,645	—	2,552,645
Special programs and meetings	168,561	—	—	168,561	—	168,561
	15,472,829	1,118,901	1,025,513	17,617,243	—	17,617,243
Administration and general:						
Office of the President	1,575,731	197,376	—	1,773,107	—	1,773,107
Office of the Executive Vice President	353,864	—	—	353,864	—	353,864
Governing boards	462,941	—	—	462,941	—	462,941
Administrative services	1,348,239	—	—	1,348,239	—	1,348,239
Information services	2,160,606	181,326	—	2,341,932	442,782	2,784,714
General expenses	1,844,732	24,420	—	1,869,152	4,106,831	5,975,983
Annual meeting	288,009	—	—	288,009	—	288,009
	8,034,122	403,122	—	8,437,244	4,549,613	12,986,857
Total expenses	23,506,951	1,522,023	1,025,513	26,054,487	4,549,613	30,604,100
Excess (deficiency) of revenue over expenses	6,251,705	(567,993)	(47,817)	5,635,895	(4,549,613)	1,086,282
Mandatory transfer for principal and interest	(3,003,850)	—	—	(3,003,850)	3,003,850	—
Council designated transfers	(2,400,000)	1,100,000	—	(1,300,000)	1,300,000	—
Net increase (decrease) in fund balances	847,855	532,007	(47,817)	1,332,045	(245,763)	1,086,282
Fund balances, beginning of year	12,131,229	3,493,194	156,014	15,780,436	11,258,560	27,038,996
Fund balances, end of year	\$12,979,084	\$4,025,200	\$108,197	\$17,112,481	\$11,012,797	\$28,125,278

Sponsored Programs

Private Foundation Support

Baxter Foundation

- Support for the Annual AAMC Award for Distinguished Research in Biomedical Science

Commonwealth Fund

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

Charles E. Culpeper Foundation

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

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 (\$42,887)
- A four-month award in support of a seminar to help academic medical centers enhance generalist education (\$10,000)
- A sub-contract with the National Public Health and Hospital Institute's strategy of urban public hospitals (\$40,264)

Henry J. Kaiser Family Foundation

- A one-year award to develop an educational enrichment program for minority adolescents (\$70,000)
- A nine-month award to identify and survey minority physicians (\$15,000)
- A three-year award to develop a minority physician database (\$490,000)

Macy Foundation

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

Federally Sponsored Programs

U.S. Department of Health and Human Services

Health Resources and Services Administrations

- A one-year contract to perform an Analysis of Career Plans, Specialty Choices, and Related Information for Postgraduate Physicians: 1987 and Comparison to Earlier Years (\$139,275)
- A purchase order for support to convene an agenda-setting conference on medical education research (\$24,500)

National Institutes of Health

- A five-year contract for the continued maintenance and development of the Faculty Roster database system (\$1,650,626)
- A purchase order for the development of a *Handbook for Instruction in the Responsible Conduct of Research* (\$19,106)

Agency for Health Care Policy and Research

- A two-year grant in support of a national conference and professional development institute for minority researchers in health services research (\$442,594)

National Institute of Mental Health

- A three-year grant to develop partnerships between high schools, colleges and medical schools to encourage minority enrollments in medical schools (\$767,471)

General Accounting Office

- A purchase order to provide automated, longitudinal data relating to medical education, taken from student and medical school questionnaires (\$18,500)

Corporate Grants

Warner Lambert Foundation

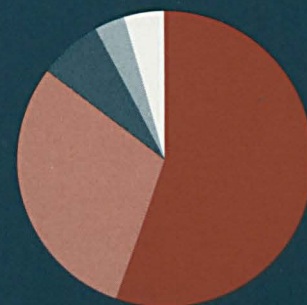
- Support for the general operation of the Association as a sustaining and contributing member

Merck and Co., and the Merck Company Foundation

- Support for the AAMC Group on Institutional Advancement's Awards for Excellence in Medical Education Public Affairs Competition

Unrestricted Current Fund Revenue

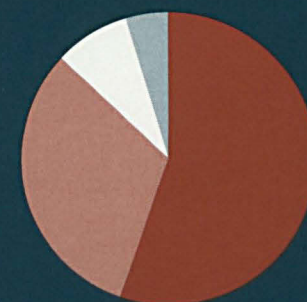
For the Year Ending June 30, 1993



- Service Programs — 55.3%
- Dues — 30.0%
- Publications — 4.3%
- Investment Income — 3.4%
- Other — 7.0%

Unrestricted Current Fund Expenses

For the Year Ending June 30, 1993



- Salaries & Benefits — 55.6%
- Supplies & Services — 31.7%
- Travel & Related — 8.3%
- Facilities Costs — 4.5%

AAMC Committees

The Executive Committee 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.

Flexner Award Committee

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

Chair

Paul F. Griner, M.D.
Strong Memorial Hospital,
Rochester

J. Claude Bennett, M.D.
University of Alabama
School of Medicine

Robert M. Carey, M.D.
University of Virginia
School of Medicine

Norman H. Edelman, M.D.
University of Medicine and
Dentistry of New Jersey
Robert Wood Johnson
Medical School

James H. Herndon, M.D.
University of Pittsburgh
School of Medicine

Allen W. Mathies, Jr., M.D.
Huntington Memorial Hospital,
Pasadena

Layton McCurdy, M.D.
Medical University of South
Carolina College of Medicine

Baxter Award Committee

Chooses recipient for Annual Baxter Award for Distinguished Research in the Biomedical Sciences.

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Francisco, School of Medicine

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University of Texas Medical
Branch, University of Texas
Medical School at Galveston

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University of California, Davis,
School of Medicine

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School of Medicine

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University of Colorado School of
Medicine

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Brigham and Women's Hospital,
Boston

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Northwestern University
Medical School

Outstanding Community Service

Selects member institution or organization with long standing, major institutional commitment to addressing community needs.

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of Medicine

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Physicians and Surgeons

N. Lynn Eckhart, M.D.
University of Massachusetts
Medical School

Morton I. Rapoport, M.D.
University of Maryland Medical
System

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

AAMC Appointees to the ALPHA OMEGA ALPHA Distinguished Teacher Award Committee

Selects recipients for two teaching awards.

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Cornell University Medical
College

Harold Ginsberg
Columbia University College of
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Vivian W. Pinn, M.D.
National Institutes of Health

Clinical Sciences

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University of Iowa College of
Medicine

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University of Alabama School of
Medicine

Anthony P. Tartaglia, M.D.
Albany Medical College

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

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of Medicine

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Yale University School of
Medicine

Gail H. Cassell, Ph.D.
University of Alabama School of
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Dartmouth-Hitchcock Medical
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Receives and acts on resolutions for presentation to the Assembly.

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University of California, Los
Angeles, Family Health Center

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Audit Committee

Reviews and approves the AAMC's financial reports.

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The Medical Center at the
University of California,
San Francisco

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School of Medicine

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debate and recommends
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Through its groups, the Association supports professional development activities for a range of medical center officials. Group programs facilitate interaction among these professionals and with Association staff and governing bodies.

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AAMC Staff

The entire Association was saddened by the death of Robert H. Waldman, M.D., AAMC vice president for Medical Student and Resident Education, of cancer July 10 at his home in Alexandria, Virginia. He had fought the disease valiantly for more than a year.

Dr. Waldman was dean and professor of Internal Medicine at University of Nebraska College of Medicine from 1985 to 1991. There he gained recognition for developing innovative programs to attract and prepare students for primary care practice in rural areas. Before joining the AAMC, Dr. Waldman was active in Association affairs and had been a member of the Council of Deans Administrative Board since 1985. Prior to his Nebraska appointment, Dr. Waldman was chair of Internal Medicine at West Virginia University School of Medicine for nine years and served as interim dean from 1982 to 1983. He also served as chief of Infectious and Immunologic Diseases and acting department chair at the University of Florida College of Medicine.

Division of Biomedical Research

John W. Diggs, Ph.D., joined the Association in June as vice president for Biomedical Research, succeeding Thomas Malone, Ph.D., who retired. Dr. Diggs will lead the AAMC division that has primary responsibility for Association programs to support biomedical and behavioral research and that deals with such issues as funding, training,

technology transfer, university-industry relations and fraud and misconduct in research.

Before joining the AAMC, Dr. Diggs was deputy director of Extramural Research at the National Institutes of Health where he oversaw more than \$6 billion in research grants to universities and research centers in the United States and abroad. His office also was responsible for human subject protection, animal welfare, research training policies, institutional liaison, invention reporting and coordination of research funding for small businesses.



John W. Diggs, Ph.D.

Division of Medical Student and Resident Education

M. Brownell Anderson was promoted to assistant vice president for Educational Programs. She joined the AAMC in 1983 as a staff associate in the Division of Educational Measurement and Research. She was promoted to senior staff associate in 1987 in the Section for Student and Educational Programs and two years later was promoted to director of Educational Programs. She is responsible for staffing the Group on Educational Affairs, the Research in Medical Education Committee, is the Executive Secretariat for the Society of Medical College Directors of Continuing Medical Education and serves as project director of the Assessing Change in Medical Education—The Road to Implementation (ACME-TRI) project.

Division of Clinical Services

Linda E. Fishman has been named assistant vice president in the Division of Clinical Services. She joined the Association in January 1987 as a research associate and was promoted to senior research associate in 1989. Her major areas of responsibility are hospital payment policy development and management of the COTH financial and general operating database. She also staffs the Task Force on Graduate Medical Education Financing Issues.

Office of Administrative Services

Jeanne McCarroll has been promoted to assistant vice president for Administrative Services. Her first position with the AAMC was controller in the Division of Business Affairs in 1979. She was promoted to associate director in 1984 and her next promotion

took place in 1987 when she became director of financial Services. Her responsibilities include the preparation and monitoring of the annual budget, fiscal management of government contracts and private grants, negotiating government indirect cost rates, preparation of annual IRS and state information returns, preparation of financial reports and income and expense projections and acting as deputy for the vice president of Administrative Services.

Scholar-in-Residence

Debra Gillers, associate dean and director of Admissions, State University of New York at Stony Brook, joined the Association from January through May as a scholar-in-residence. She developed materials for the assistance of AAMC members in addressing increas-

ingly prominent issues in medical school admissions—those associated with generalism in medicine and the assessment of applicants with disabilities. She conducted two surveys related to admissions strategies. The first focused on admissions policies pertaining to medical school applicants with disabilities and the second gathered information on how admissions committees are responding to the generalist initiative. She also initiated a series of case studies designed for future management workshops on admissions issues.

Seated: Donald G. Kassebaum, M.D., John W. Diggs, Ph.D., Edwin L. Crocker, and Herbert W. Nickens, M.D. **Standing:** Kathleen S. Turner, Richard M. Knapp, Ph.D., Robert G. Petersdorf, M.D., Edward J. Stemmler, M.D. Elizabeth M. Martin, Joseph A. Keyes, Jr., J.D. **Not pictured:** Robert M. Dickler.



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