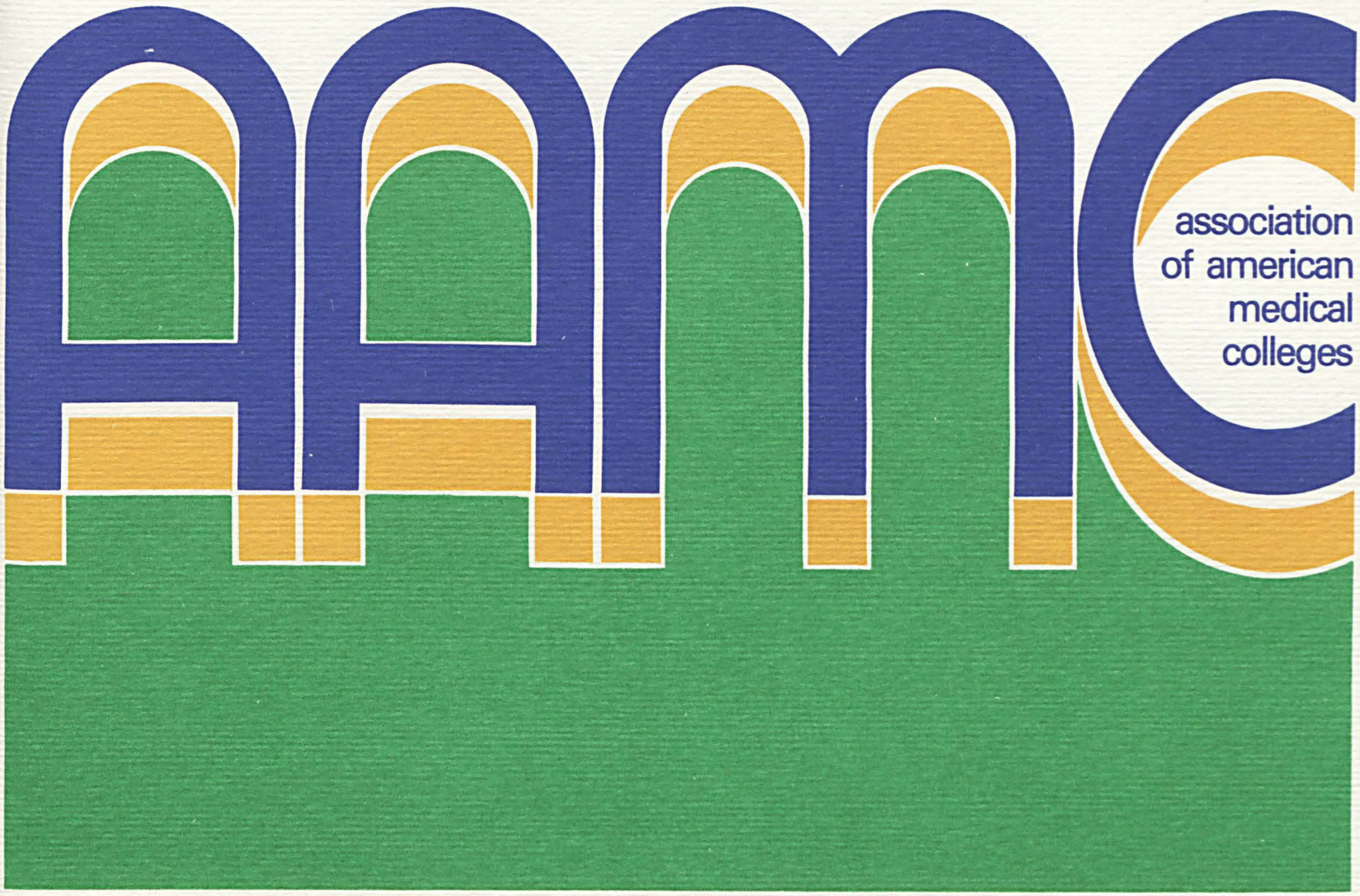
78-79 annual report



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Charles B. Womer

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Council of Teaching Hospitals

John W. Colloton
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Organization of Student Representatives

Dan Miller
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Stuart Bondurant*
Christopher C. Fordham, III*

Chairman, Council of Teaching Hospitals
Secretary-Treasurer
Robert M. Heyssel

*Dr. Fordham served as Chairman from October 1978 to August 1979; Dr. Bondurant will serve as Chairman until November 1980.

1978-79 ANNUAL REPORT

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

CONTENTS

President's Message

The last two decades have been a turbulent period in the history of our country. The quiet Eisenhower years gave way to an era of assassinations, violent civil rights protests, student revolts, a debilitating war in Vietnam, scandals in the executive and Congressional branches of the federal government, accelerating urbanization that brought serious problems including decay of inner cities, an energy crisis, double-digit inflation, and a severely weakened dollar. However, until recently, real individual incomes have risen; people are doing better; and, despite what John Knowles said, not all are feeling worse.

In the midst of this turmoil, medicine and medical education have changed, mostly for the better. The new knowledge flowing from an expanded research effort transformed medical practice and moved it a considerable way from empiricism to a more solid scientific basis with a corresponding greater capability in the prevention, diagnosis, and amelioration of disease. Life expectancy has been extended, and significant reductions in morbidity have been achieved. As a result, the American people have raised their expectations of medicine, and this has brought greater demand for medical care. With increasing demands have come more public anxiety and concern about the cost, quality, and accessibility of these services. This outcome was predicted by Jerome Bruner in 1962: "With technological advance, more things are possible, but social and technical organization is increasingly necessary to bring them off. In effect then, the sense of potency—the idea of the possible—increases in scope, but the artificer of the possible is now society rather than the individual." As Bruner foretold, we have suffered exponential intrusion of government into medicine and medical education through mounting directive legislation and regulation. This intrusion has resulted in a severe restriction on the past freedoms and capabilities of medical schools to innovate.

The Association of American Medical Colleges has undergone far-reaching changes during the last decade. In response to the recommendations of the 1965 landmark report of its Coggeshall Committee, the Association has been transformed from a "Deans' Club" into an organization broadly representative of all those involved in the increasingly complex structure of the medical school and its affiliated institutions. It also accepted the challenge to commit itself to a greater leadership role in medical education, biomedical research, and medical care to serve the nation, the community and its members.

One of the recommendations of the Coggeshall Report, "Planning for Medical Progress Through Education," was that the Association appoint a full-time President as its chief executive officer. This was not the most remarkable of the Report's recommendations, but it did have deep personal importance to me. For it was ten years ago that I was asked to assume this post and it was for the Association's 1969 Annual Meeting in Cincinnati that I wrote my first message as President of the Association. Since anniversaries are traditionally occasions for retrospection as well as for looking ahead, I thought it important to reflect on recent accomplishments of the Association and to review changes in the organization over the past decade, changes that reflect the shifting environment in which the Association and its constituents have operated.

The medical schools have grown in size, complexity and function. The number of schools has increased from 99 in 1969 to 126 today. The number of undergraduate students has risen from 35,000 to 62,000. This 75 percent growth in ten years equals that of all three previous decades. Not only have the medical schools increased the number of graduates, but they have also assumed a broader role in the continuum of medical education. Now more than 90 percent of the residency programs are in teaching hospitals associated with medical schools. This contrasts with less than 50 percent 15 years ago. This greater involvement brings increased responsibility for the medical schools to assure the quality of residency training and to relate it to the nation's needs for physicians. Continuing medical education has grown enormously in the last decade as one effort to improve the quality of medical care provided by practicing

physicians. Medical school faculties have become major participants in continuing medical education through programs offered by the medical schools or through professional societies and associations. A host of other learners in the academic medical center have put additional burdens on medical school faculties. In 1969, the facilities were involved in teaching a total of 89,000 students of all types; by 1976, the number had increased to about 155,000.

Faculty involvement in biomedical research has not grown concomitantly, in spite of the seminal contributions that new knowledge has made to the advancement of medicine. Although appropriations for the National Institutes of Health, the major source of support for biomedical investigations, have risen from $1.1 billion in FY 1969 to $3.2 billion in FY 1979, this additional funding does not represent any real increase in research effort because of inflation and higher costs of more sophisticated investigations. Fragmentation of funding by "disease of the month" campaigns and detailed directives in federal legislation have significantly reduced the flexibility to pursue the most promising directions in research.

During this period, the Administration, and particularly the Office of Management and Budget, heightened their opposition to federal involvement in research training. As a result, more restrictions have been placed on support for preparing the next generation of investigators. These constraints, along with the plateau in research grant funding, threaten the national research endeavor and the future supply of faculty for the medical schools.

The situation is quite different with regard to medical services provided by the academic medical centers. To assure the transfer of new knowledge from the research laboratories into medical practice and to meet society's demands for complex, tertiary care, the full-time clinical faculties expanded from 15,916 in 1969 to 33,059 in 1979 and became more involved in medical care. Over 20 percent of acute inpatient hospital days are now provided by the 323 non-federal members of the Association's Council of Teaching Hospitals which constitute only 5.4 percent of the nation's hospitals. In addition, Veterans Administration hospitals affiliated with medical schools and belonging to the Council provide over two-thirds of VA inpatient hospital days, though they make up only about half of the hospitals in that system.

Medical schools have also extended their activities beyond the walls of the academic medical center through affiliations with many community hospitals and VA hospitals and through the creation of area health education centers with other institutions involved in health professional education and patient service. These developments have contributed to the dissemination of new knowledge and technology, the improvement of the quality of medical care, and better geographical distribution of physicians.

The growth and changes in academic medical centers over the past decade have been reflected in the financing of their activities. The total budgets of the medical schools have more than trebled. In 1969, over one-half of medical school budgets came from federal grants and contracts. Now less than one-third comes from this source. Increased state government support has been of critical importance to both public and private medical schools, and professional fee income from medical practice by the clinical faculty has become more important as other sources of revenue have lagged behind the medical schools' needs. However, many private and some publicly controlled medical schools have been forced to increase tuition fees substantially in order to maintain their fiscal viability.

These changes in the sources of revenues threaten the balance in medical education, research, and patient care activities. The expanded involvement of the clinical faculties in medical service is diminishing the time they can devote to education and research. Moreover, increased tuition and inadequate sources of student financial assistance are making it difficult to sustain efforts to broaden the socioeconomic levels of medical school classes and to improve opportunities for underrepresented minorities.

The growth in size and function of the academic medical centers and the problems of obtaining adequate financial support for their activities have brought about important changes in the relationships of the medical school to its parent university. University officials and trustees have become more active in medical school affairs. The issues that have raised the university level of concern center primarily around medical service activities and university-owned teaching hospitals. Because of these concerns, many institutions have created the position of vice president for health affairs. Although the role of

these vice presidents varies widely, in some cases they have been given broad responsibilities over the educational and patient care activities of the medical school and university-owned teaching hospitals. The new organizational pattern has weakened the ties of the medical school to the remainder of the university and has often created difficulties in defining the roles of deans and hospital administrators. The resulting instability comes at a time when cohesively, effectively operating academic medical centers are of rising importance.

The Association has responded in several significant ways to the changing world in which the medical schools operate and to the recommendations of the Coggeshall Report that it assume a greater leadership role in medicine and medical education and provide more effective support to the academic medical centers.

The membership and governance structure have been expanded to give full participation for teaching hospital administrators and faculties in the Association's activities. The Council of Teaching Hospitals now has 418 members and represents the major institutions involved in undergraduate and graduate medical education, clinical research, and complex and high intensive tertiary care.

Membership in the Council of Academic Societies has doubled since 1969, and its 67 societies represent more than 100,000 individuals. The Organization of Student Representatives, formed in 1971 with participants from 112 medical schools, brings the student voice into the development of policy and programs. Members of the Councils of Teaching Hospitals and Academic Societies have been elected chairmen of the Association, giving further evidence of the complete integration of members into the organization. The addition of Distinguished Service and Emeritus Members has further broadened the scope of the Association. All segments of the academic medical center now work effectively in concert to develop the policies and programs of the Association and make it an effective spokesman to policymakers. Its voice is respected by government and in the councils of private sector professional societies and organizations. The recommendations of the Coggeshall Committee are thus well along the way to implementation.

The Executive Council has served as a very effective body for directing the affairs of the Association. Consensus views of the governance structure usually are reached with dispatch and largely without the difficulties predicted for such a diverse group. It has represented the Association with distinction in interactions with the federal executive branch and the Congress. It has augmented its impact on seminal issues by the appointment of committees and task forces which have undertaken extensive studies and made important recommendations. The Assembly has debated critical policy issues and provided a broad input into Association policy.

The Association has also implemented the Coggeshall Report recommendation to become more involved with other groups in education and health and broaden its influence on national policy issues. It was instrumental in creating the Coalition for Health Funding, which brings together the efforts of 55 private sector organizations to improve the level of funding for federal health programs. The Association also joined with four other major medical organizations to establish the Coordinating Council on Medical Education to develop broad policy and has been a major contributor to the development of the Liaison Committees on Graduate Medical Education and Continuing Medical Education. On a regular but less formal basis, Association representatives meet with officials of other scientific or educational organizations to discuss and act on issues of common importance.

To obtain the advice and counsel of a distinguished group of private citizens and to promote a better understanding of the Association's objectives and programs and of the needs of the academic medical centers, the Association established a National Citizens Advisory Committee for the Support of Medical Education. The committee members are 53 prominent individuals from business, the arts, and civic affairs. Through its issue papers and contacts with policymakers, the Committee has been important in making public the Association's messages.

There have been other important changes in the opportunity for broader involvement in Association activities. Five groups have been formed around special segments of the academic medical centers to facilitate communication between those in different institutions with similar interests, to provide a mechanism for more effective involvement with Association programs, and to serve as a means for

professional development. The Groups on Student Affairs, Business Affairs, Medical Education, Public Relations, and Planning now have a membership of 3,000. The Group on Public Relations has recently been expanded to include development and alumni officers in institutions. The groups meet regionally and at the annual meeting to discuss professional interests.

The recommendation of the Coggeshall Committee that the Association move its headquarters from Evanston, Illinois, to Washington, D.C., was accomplished in 1970 with little difficulty in the midst of the reorganizations of its membership and governance. This move and the strengthening and expansion of the staff have been important factors in providing more support to the members and in moving the Association ahead on the national scene.

In keeping with these litigious times, the Association has been increasingly involved in the courts, particularly the federal courts, either as a plaintiff or amicus curiae to try to overturn or moderate damaging legislaton or regulation. The outstanding success in the legal arena was the forced release of $225 million in research funds impounded by the Nixon Administration. The Association has also participated actively in hearings held by federal agencies. The action of the National Labor Relations Board in defining residents as students, rather than employees, was an outcome of this kind of effort.

The total annual budget of the Association has more than trebled since 1969. At the same time, there have been notable changes in the sources of revenue. In FY 1969, 31 percent of the income was from membership dues; in FY 1979 only 20 percent came from this source, but this component of income has been, and continues to be, critical for Association programs. Income from grants, contracts, and services now accounts for three-fifths of the Association's revenue.

There have been a number of new programs undertaken over the past decade with the assistance of steering committees drawn from the constituency and with financial support largely from foundations and government agencies. One of the most effective of these programs has been the Management Advancement Program which is designed to improve the management capabilities of deans and their management teams, department chairmen, and teaching hospital administrators. More than 800 individuals have participated in 40 seminars made possible by a generous grant from the Robert Wood Johnson Foundation. Among other activities and programs have been studies of the characteristics of medical schools; affiliation agreements; primary care education; the teaching of quality assurance and cost containment; health maintenance organizations; three-year medical school curricula; medical school curricula; medical practice plans; the source, mobility, and career patterns of faculty; characteristics of medical school applicants and enrollees and their financial criteria for selecting students; and a major followup and analysis of the longitudinal study of medical students begun in 1956.

The American Medical College Application Service (AMCAS), a centralized application service to help schools deal with a growing number of applicants, was initiated in 1969, with seven schools and 7,500 applicants filing 13,610 applications. In 1980, 96 schools will participate in AMCAS, which will process 300,000 applications for more than 30,000 students. After its shakedown period, AMCAS has been remarkably error free, even though over three million pieces of paper are handled in the program each year.

Another major service to members and applicants was the complete revision of the Medical College Admission Test (MCAT), which has been given under Association auspices since 1930. With extensive involvement of deans, admission officers, faculty, minority representatives, practicing physicians and evaluation experts, a New MCAT was devised and first administered in 1977. The new test forms provide a more extensive evaluation of the knowledge applicants possess in the premedical sciences and their ability to solve problems similar to those confronted by a physician.

The increased sensitivity of medical schools toward women and minorities has been reflected by the Association. The AAMC Office of Minority Affairs, established in 1969, has assisted medical schools in their efforts to increase minority representation and to eliminate obstacles that limit the participation of minorities in the health professions. A major project of this office has been the Simulated Minority Admissions Exercise to improve the use of noncognitive criteria in selecting minority students. This effort was followed by a special emphasis on women in medicine. A network of Women Liaison Officers gives women in academic medicine an opportunity to interact with the Association, and the annual

meeting program has been enriched by special Women in Medicine activities. An effort to assist in the recruitment and promotion of minority and women faculty members is now underway.

For a membership organization like the AAMC, communication with its constituents is vital to its effectiveness. For more than half a century the Association has published the *Journal of Medical Education*, which, in recent years, has been augmented by a number of other periodic communications. The Weekly Activities Report, created in 1970, reports on Association activities, national developments, and federal legislation and regulation to more than 9,000 subscribers. Other publications include the COTH Report, the Student Affairs Reporter, the Organization of Student Representatives Report, the Council of Academic Societies Brief, and Management Advancement Program Notes. Special Assembly and Deans' memoranda on important and urgent policies and issues have tripled in volume since 1969.

A major responsibility of a constitutent association is the collection and analysis of information on its members and their characteristics. The Association's capability in this area was substantially increased by the development of a competent staff and the acquisition of a computer system. The Institutional Profile System, operational since 1972, has grown to contain 14,515 variables from 76 different sources, and comprises the data base to respond to member requests for information and for a number of studies the Association has undertaken in the last several years. The Faculty Roster, the data base for targeted studies on faculty, includes information on 80,000 individuals who are serving or who have served on medical school faculties during the last decade. Additional data systems exist on applicants, students, and teaching hospitals.

The accomplishments of the Association in the last ten years have been due in large part to the leadership and contribution of hundreds of individuals who have served tirelessly on the Executive Council, the Administrative Boards, task forces, and committees. Although the last decade has been an exciting period of growth and accomplishment for the Association, we cannot become complacent.

The challenges of the next decade will be even more demanding. For example, we are moving to respond to an important recommendation of the Coggeshall Report: "Those responsible for medical education—faculty members, deans, university officials, trustees, and legislators—will, in decades ahead, need to devote careful attention to appraising the needs of society for health care and health personnel and to developing and implementing plans to meet those needs. Failure to do so will damage the standing of the profession and educational institutions and will incite—even make necessary—less desirable approaches to meeting the health care needs of a growing America. If those responsible for medical education fail to assume and act on a responsibility that is now clearly theirs, it will be assumed by others."

This and other opportunities to advance the nation's health remain urgent items for the Association's agenda.

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

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David M. Brown
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Virginia V. Weldon
Frank C. Wilson
Frank E. Young

Council of Deans

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Christopher C. Fordham, III*

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John E. Chapman
Neal L. Gault, Jr.
Richard Janeway
Julius R. Krevans
William H. Luginbuhl
Allen W. Mathies, Jr.
Richard H. Moy

*Dr. Fordham served as Chairman from October 1978 to August 1979; Dr. Bondurant will serve as Chairman until November 1980

Council of Teaching Hospitals

Chairman
Robert M. Heyssel

Chairman-Elect
John W. Colloton

Dennis R. Barry
Jerome R. Dolezal
James M. Ensign
David L. Everhart
Mark S. Levitan
Stuart Marylander
Robert K. Match
Mitchell T. Rabkin
Malcom Randall
John Reinertsen
Elliott C. Roberts

Organization of Student Representatives

Chairperson
Peter Shields

Chairperson-Elect
Dan Miller

Barbara Bergin
Arlene Brown
John Cockerham
Kevin Denny
Seth Malin
Molly Osborne
Paul Scoles
Stephen Sheppard
Alan Wasserman

The Councils

EXECUTIVE COUNCIL

At its four meetings the Executive Council discussed and acted on many issues affecting medical schools and teaching hospitals and their faculty and students. Policy questions came to the attention of the Executive Council from member institutions or organizations or from one of the constituent Councils. Policy matters considered by the Executive Council were first referred to the constituent Councils for discussion and recommendation before final action.

The December retreat for the Association's elected officers and executive staff offered an opportunity to consider evolving relationships with the Food and Drug Administration and the Federal Trade Commission, two government agencies with increasing interaction with medical schools and the health profession. The discussion about the FDA at the retreat and later Executive Committee meetings led to the establishment of an FDA Liaison Committee to facilitate formal meetings between high level FDA staff and medical school and teaching hospital faculty. Retreat discussions also considered pressures from government and other sources to adapt medical school curricula to address more explicitly societal problems such as nutrition and geriatrics. The staff has been encouraged to explore ways to help schools review and evaluate their curricula in response to such pressures. A major concern at the retreat was the decision by the Office of Management and Budget to rescind FY 79 appropriated funds and drastically reduce FY 80 levels for a number of health programs, including medical student capitation awards, student assistance programs, and research funding. The decision was made to undertake an immediate and vigorous challenge to these proposals. An annual reassessment of the Association's relations with other voluntary health organizations focused on the Liaison Committee on Graduate Medical Education. The retreat endorsed a plan that would have established the LCGME as an independent legal organization with responsibility for policy-making and accrediting programs in graduate medical education.

Throughout the year the Executive Council actively reviewed the Association's participation in the Coordinating Council on Medical Education. The Association's proposal for increased independence for the LCGME was presented to the CCME Parental Commission on the Structure and Function of the LCGME. Although other CCME parent organizations were unwilling to consider a radical restructuring of the LCGME, general agreement was reached that it was necessary to provide a more formal structure for the staffing requirements of the LCGME and to invest more authority in the LCGME's officers. A decision by the American Medical Association to withdraw from the Liaison Committee on Continuing Medical Education caused considerable debate at the Executive Council. The Executive Council took the position that the withdrawal of one organization did not dissolve the LCCME and voted to continue AAMC participation in the LCCME, and approved several changes in LCCME operations proposed by the remaining members of the LCCME as the transition from AMA staffing activities was effected. The Executive Council's review of CCME activities included discussion and approval of reports from CCME committees on the continuing competence of physicians, opportunities for women in medicine, and the coordination of data on physicians. An important and satisfying action came with AAMC approval of revisions in the general requirements section of "The Essentials of Accredited Residencies in Graduate Medical Education." This revision, the first since the section was adopted in 1972, places significant responsibility on institutions providing graduate medical education to develop internal policies and procedures ensuring the quality of their educational programs.

The Executive Council's continuing review of important medical education policy areas was augmented by the work of a number of specially appointed committees and task forces. The Association's Task Force on Graduate Medical Education, chaired by Dr. Jack D. Myers, presented its reports to the Executive Council and Administrative Boards, to a special invitational meeting of house staff, and to the 1979 Assembly. The final report will include recommendations from five working groups: The Working Group on Quality chaired by

Dr. Samuel B. Guze; the Working Group on National Standards Formulation and Accreditation chaired by Dr. Gordon W. Douglas; the Working Group on Transition Between Undergraduate and Graduate Medical Education chaired by Dr. D. Kay Clawson; the Working Group on Specialty Distribution chaired by Dr. Theodore Cooper; and the Working Group on Financing chaired by Dr. Edward J. Stemmler. Publication of the final report is targeted for March 1980. The Henry J. Kaiser Family Foundation, the Educational Foundation of America, and the W. K. Kellogg Foundation have supported the work of the Task Force and its Working Groups.

The preliminary report of the Task Force on the Support of Medical Education, approved by the Assembly in 1979, served as a basis for discussions between Task Force Chairman Edward Stemmler and other AAMC officials and Congressional leaders and White House staff. Both the executive and legislative branches indicated a willingness to receive the views of the medical education community on politically and economically feasible forms of student assistance and institutional support. The Task Force has also done extensive work in laying the groundwork for the Association's participation in the renewal of manpower legislation, through the preparation of a preliminary report outlining the issues and possible alternatives in renewal legislation. The Task Force will also participate in legislative activities on student assistance programs.

The Executive Council approved the transmittal to all medical schools of the final report of the Special Advisory Panel on Technical Standards for Medical School Admission. The Panel had been established to review HEW regulations on Section 504 of the Vocational Rehabilitation Act of 1973, as amended, a statute that established a broad governmental policy forbidding discrimination on the basis of handicap. The Panel's report, while condemning denial without cause of medical school admission to handicapped individuals, recommended that certain minimum technical standards be required in the admission process. The Panel concluded that a candidate for the M.D. degree should have abilities and skills of five varieties including observation; communication; motor function; conceptual, integrative and quantitative abilities; and behavioral and social attributes. The Panel's report was an appendix to the Association's *amicus curiae* brief in *Southeastern Community College v. Davis*, in which AAMC argued that the determination of admissibility of any candidate to medical school must be left to the sound judgment of the medical faculty applying appropriately developed technical standards, and further argued that some handicaps would disqualify some persons from the full course of training necessarily required of all physicians. This position was supported in the Court's unanimous decision that institutions may require reasonable physical qualifications for admission to a clinical training program and that Section 504 imposed no requirement upon an educational institution to lower or to effect substantial modifications of standards to accommodate handicapped persons.

Another committee whose final report was approved by the Council dealt with Clinical Laboratory Improvement legislation. The report recommended that the Association not support the 1979 CLIA legislation because the government had sufficient authority to control laboratory fraud and abuse, estimates of laboratory error were high, significant improvements in laboratory performance had already been noted, and an enormous regulatory bureaucracy would be necessary to enforce the legislation.

The Association's Committee on Continuing Medical Education completed its work, recommending basic principles for continuing education for physicians and defining appropriate roles for medical schools, teaching hospitals, and the Liaison Committee on Continuing Medical Education.

James Mongan, Director, Office of Planning and Evaluation, Office of the Assistant Secretary for Health, appeared at a joint session of the Administrative Boards to discuss President Carter's National Health Plan. As a result of heightened Congressional and executive branch activities on health insurance proposals, the Association convened a National Health Insurance Review Committee to examine alternate legislation and make recommendations for an Association position on an expanded and improved insurance program.

A number of research-related issues required Executive Council attention, including support for General Clinical Research Centers, clinical research opportunities for medical students and faculty, the proposed Health Science Promotion Act, and the need for more effective liaison with the Alcohol, Drug Abuse and Mental Health Administration. This latter problem was solved by the establishment of an AAMC/ADAMHA Liaison Committee which was asked to give immediate attention to regulations concerning research and the institutionalized mentally infirm and research manpower for ADAMHA-related disciplines. A particularly difficult problem was the HEW Notice of Proposed Rulemaking requiring HEW grantees to have a

compensatory mechanism for injured research subjects. A detailed discussion of the issue led to a recommendation to the Secretary of HEW that the matter be referred to the Department's Ethics Advisory Board.

Testing was another subject that appeared in many guises before the Executive Council. The most troubling instance was New York state testing legislation, the disclosure provisions of which were so onerous that the Association announced it would withdraw New York as an administration site for the New MCAT examination. A proposal by the Federation of State Medical Boards' Committee on Continued Study of Licensure prompted considerable discussion. The proposal would institute a new system of two FLEX exams for all physicians. FLEX I would be administered prior to entry to graduate medical education and would grant a license to practice under supervision in a residency training program; FLEX II would qualify a physician for an unrestricted license to practice. The Executive Council worked with the National Board of Medical Examiners to consider alternatives to Part I of the NBME that might be considered to assess knowledge in basic medical sciences and introductory knowledge in clinical diagnosis for evaluating transfer students who wish to be considered by medical schools.

The Executive Council was actively involved in debate on regulations implementing two sections of the 1972 Social Security Amendments. Following recommendations of its Committee on Section 227, the Association had been successful in attempts to delay implementation of Section 227 regulations and planned careful scrutiny of the new regulations promised by HEW. With respect to Section 223, the Executive Council approved a four point program of meetings with HEW to discuss constituent problems, a request to Congress for suspension of Section 223 regulations, coordination of information and advice for hospitals seeking judicial relief, and an effort to determine a methodology for quantifying the intensity of patient services provided by hospitals and the exploration of the usefulness of this information in establishing reimbursement policies for medical services.

As a participant in the Educational Commission for Foreign Medical Graduates the Association, through the Executive Council, reviewed ECFMG activities and recommended that the ECFMG, because of its primary role and function as a screener of qualifications of foreign medical graduates, should not be involved in influencing legislation relating to the criteria for the admission of foreign medical graduates. It urged ECFMG to collect and analyze data on the impact of the changes introduced by P.L. 94-484.

The use of the Faculty Roster to facilitate the recruitment and promotion of minority and women faculty was approved by the Executive Council. By updating information contained on the Roster for women and minorities, the Association will have a valuable reference for identifying female and minority candidates for academic positions in medical schools, advisory committees for federal agencies, and elsewhere.

During the year the Executive Council continued to oversee the activities of the Group on Student Affairs, the Group on Medical Education, the Group on Business Affairs, the Group on Public Relations, and the Planning Coordinators' Group. The Group on Public Relations was expanded to include the activities of alumni and development officers.

Prior to each Executive Council meeting the Executive Committee met and business was conducted by conference call as necessary.

The Executive Council, along with the Secretary-Treasurer, Executive Committee and Audit Committee, exercised careful scrutiny over the Association's fiscal affairs, and approved a slightly expanded general funds budget for fiscal year 1980.

COUNCIL OF DEANS

The activities of the Council of Deans in 1978-79 centered on business meetings and program sessions conducted at the Association's annual meeting in New Orleans and the Council's spring meeting in Scottsdale, Arizona. During the intervening periods the Council's Administrative Board deliberated on the Executive Council agenda items of significance for the Association's institutional membership. More particular concerns were dealt with by groups of deans brought together by common interests.

Actions taken at the Council's annual business meeting included endorsing a statement discussing the ethical issues involved in the withholding of medical care by physicians and approval of a resolution proposed by the Organization of Student Representatives urging the establishment of a joint committee of the OSR, CAS and COD to investigate possibilities for improving and encouraging research opportunities for medical students. The primary focus of the business meeting was a discussion of the progress of the Association's task forces and committees, including reports on minority student opportunities, student financing, financial support of medical education, graduate medical education,

continuing medical education and biomedical research policy developments.

The program session of the annual meeting was conducted under joint sponsorship with the Council of Academic Societies and the Council of Teaching Hospitals, and continued the plenary session theme of the impact of government regulation on medical education. Alan Palmer, Deputy Director of the Federal Trade Commission's Bureau of Competition, and Dr. Julius Krevans, Dean of the University of California, San Francisco, School of Medicine, discussed the applicability of traditional economic models to health care and the public responsibilities that are associated with the concept of "profession" as opposed to "trade." During the second segment of the program Professor Laura Nader, an anthropologist from the University of California at Berkeley, and Dr. Ivan Bennett, Jr., Dean of the New York University School of Medicine, debated the role of public sector regulation of biomedical research.

Ninety-four deans attended the annual spring meeting of the AAMC Council of Deans on April 22-25, devoted to a series of current issues in medical education including medical education and the university, the transition between pre-professional and professional education, critical values in medical education, and minority student opportunities in the post-Bakke era. Scholarly and thought provoking presentations generated immense interest among the deans and stimulated extensive and energetic discussions.

Dr. Henry Foley, Administrator of the Health Resources Administration, joined the Council of Deans to present a brief review of the Carter Administration's stance regarding the renewal of approximately 23 provisions of the health manpower legislation. A key point in the subsequent discussion was the devastating effect on the medical schools' trust in the constancy of federal purpose that resulted from the Administration's proposed rescission of already appropriated funds for medical school capitation grants.

During the business meeting the Council discussed a planned AAMC meeting of house officers on the report of the Task Force on Graduate Medical Education; consultations with the HEW officials drafting the Section 227 regulations; the revision of LCGME General Essentials of Accredited Residencies in Graduate Medical Education; the progress of the Association's Task Force on Graduate Medical Education; the proposal of the Federation of State Medical Boards that the current system of licensure be replaced by a new examination sequence; and a three part study of the National Council on Health Planning and Development Subcommittee on Productivity and Technology, on "efficiency" and "effectiveness" in health care. The only formal action of the Council of Deans was an endorsement of the Executive Committee decision not to recommend that the Section 223 regulations provide for each medical school to designate one or more hospital(s) as its primary teaching institution(s) as a means of developing a separate classification for routine cost reimbursement. And, as a result of discussion on the health planning legislation, it was agreed that the AAMC Executive Council would review its position on this legislation at its next meeting.

Of the many items considered by the COD Administrative Board, several deserve special note. The Report of the Panel on Technical Standards for Medical School Admission was endorsed for distribution to member schools. It subsequently formed the basis of an AAMC *amicus curiae* brief in a Supreme Court case that vindicated the right of professional schools to set reasonable physical as well as academic standards for admission. The Board also approved the outline of a proposed new examination that would replace the National Board Part I exam as an instrument for evaluating students seeking admission to medical schools with advanced standing.

Sections of the Council that met during the year were the Southern and Midwest Deans, the Deans of New and Developing Schools, and the newly formed Section of Deans of Private Freestanding Schools. The Southern Deans galvanized into action a movement for the repeal or substantial modification of the proposed limitations on the reimbursement of teaching physicians under Medicare. This movement stimulated a deferral of the effective date of the law and a revision of the regulations.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies continued to grow during its twelfth year and now represents 67 member societies. At the 1978 annual meeting, the CAS discussed a number of issues in biomedical research and graduate medical education that were the focus of the Council's attention and efforts throughout the year. Dr. Paul Beeson, Chairman of the Institute of Medicine's Committee on Aging and Medical Education, reviewed the major recommendations of his committee's final report. Also at the annual meeting, the Council sponsored a legislative workshop for CAS Public Affairs Representatives, similar in format to one held in 1976. At the

workshop Congressional and Administration staff discussed in detail the process by which laws are enacted, funded, and implemented and offered advice on how individual academic societies could more effectively interact with federal policy makers on issues of importance to their constituents.

An interim CAS meeting held in the spring discussed issues in graduate medical education. Dr. Jack Myers, Chairman of the Task Force on Graduate Medical Education, reviewed with the Council the status of each of the Task Force's five Working Groups and asked for input from the Council on the Task Force's preliminary conclusions and recommendations. Productive workshop sessions focused on specialty distribution, the transition from undergraduate to graduate medical education, program accreditation, and the proposed revision of the LCGME's General Requirements. CAS representatives participating in the workshops reviewed reports and position papers developed in each of these areas and offered specific comments and suggestions for modification. The Council also revised its bylaws to implement a new system for nomination of officers.

The two-year experimental phase of the CAS services program ended in July and the Association decided to continue the program for interested CAS societies. The services program assists societies in their efforts to serve their own constituency by providing legislative tracking services and/or society management services. The Association of Professors of Medicine has participated in the program for over two years and subscribes to both the management services and the tracking services. The other four subscribing societies—American Academy of Neurology, American Neurological Association, Association of University Professors of Neurology, and the American Federation for Clinical Research—participate in the CAS services program to receive information about issues of particular interest to their members.

The Administrative Board encouraged CAS societies to name Women Liaison Officers. This network within the medical schools now consists of representatives from approximately 115 medical schools and twenty CAS societies.

CAS societies are informed of issues of concern to faculty by the quarterly CAS Brief which now reaches approximately 15,000 members. Special memoranda or CAS Alerts are sent to the membership when issues arise requiring immediate attention and action.

The CAS Administrative Board met quarterly to conduct the business of the Council and to deliberate on Executive Council agenda items of particular importance to faculty. These quarterly meetings also allowed CAS Board members to interact with the Administrative Boards of the other Councils and to have informal discussions with representatives of the executive branch.

COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals held two membership meetings during the past year. At the 1978 annual meeting the Council sponsored a program on "Multiple Hospital Systems and the Teaching Hospital." Limiting their remarks to arrangements in which two or more hospitals surrender some of their previous institutional autonomy, Ed J. Connors, President of the Mercy Health Corporation in Farmington Hills, Michigan, discussed "the opportunities" accompanying such arrangements and Mark S. Levitan, Executive Director of the Hospital of the University of Pennsylvania, discussed "the problems" with such arrangements. Both Connors and Levitan agreed that multi-hospital systems offer some economic and clinical advantages which may challenge free-standing hospitals for capital and technological innovations; however, Connors argued that hospitals whose missions include providing the essential clinical resources for medical schools may be candidates for multi-hospital systems only if they specialize in this role and forego some acute care activities. Levitan, on the other hand, took the position that the educational/research mission made major teaching hospitals unlikely candidates for multi-hospital systems.

In May the Council held its second annual spring meeting in Kansas City, Missouri. The two-day meeting, which allows the chief executive officers of COTH hospitals to discuss common issues and concerns, opened with an evening address by Jack Lein, M.D., Associate Dean for Continuing Education and Development at the University of Washington School of Medicine, who discussed the need and appropriate methods for active participation in the legislative and policy-making process at all levels of government.

Another session, "Toward a More Contemporary Public Understanding of the Teaching Hospital," summarized the highlights of a staff paper prepared on the teaching hospital. Following the presentation, attendees met in workshops to review the paper in the context of major issues related to hospital reimbursement, health planning, and national health insurance. While the individual workshops were organized around three separate topics, there

was a remarkable consistency in the recommendations developed by the workshop groups. Essentially, each workshop concluded that the problems facing teaching hospitals in the future resulted from three factors: atypical service costs resulting from the complexity or intensity of care provided patients; atypical institutional costs resulting from educational program activities; and a wide variation in each of these costs among teaching hospitals. Because of the variation among teaching hospitals, each discussion group recognized that methodologies were needed to quantify intensity and educational costs so that teaching hospitals could be classified into homogeneous groups or scaled into continuous distributions. The discussion groups felt that a study to quantify the intensity of patient care and the costs of educational programs could be used to familiarize planning agencies and the general public with the unique requirements of teaching hospitals, to propose new approaches for hospital reimbursement schemes or payment limitations, and to evaluate proposed reimbursement and limitation schemes.

Four concurrent sessions were held on special topics: "The Maxicap Experiment: Present Status and Future Probability;" "The Manpower Component of the State Health Plan;" "An Informal Session with the Staff of the Voluntary Effort;" and the "Role of Veterans Administration Medical Centers with Medical Schools."

A final session discussed "State Rate Review and the Teaching Hospital," first reviewing the experiences with the Maryland State Rate Review body and then debating whether COTH should support immediate development of state rate review agencies.

The COTH Administrative Board met quarterly to develop and review the Association's program of teaching hospital activities. Preceding its January meeting, the Board met with Dr. Karen Davis, DHEW Deputy Assistant Secretary for Planning and Evaluation/Health. Dr. Davis outlined the Carter Administration's continuing support for hospital cost containment legislation and described the principal features of the bill to be submitted early in 1979. She also described some of the Administration's thinking on a national health insurance proposal. These national health insurance options were clarified in March when a joint Administrative Board session heard Dr. James Mongan, Director, Office of Planning and Evaluation, Office of the Assistant Secretary for Health, describe the major policy questions the Carter Administration faced in reaching final decisions on its proposal.

Much of the specific teaching hospital content of this year's Board meetings focused on two reimbursement issues: payment limits for routine services provided to Medicare beneficiaries and experimental/research methods for measuring the intensity of patient case mix. In March the Health Care Financing Administration (HCFA) had proposed a new schedule of limits on payments to hospitals for routine inpatient services for Medicare beneficiaries. Using several concepts from Senator Herman Talmadge's Medicare-Medicaid reform bill, HCFA estimated that the number of hospitals exceeding the limits would increase from 800 to 1200 and disallowed costs would increase from $100 million to $225 million annually. Initial data showed that these increased disallowances were atypically concentrated in teaching hospitals. The Board gave this matter significant attention at both its March and June meetings, providing guidelines for Association comments on draft regulations in March and planning a national meeting with HCFA for early July to discuss the final regulations. Also at its June meeting the Board gave major attention to the case mix and educational cost recommendations developed at the Council's spring meeting. Under Board direction, Association staff are conducting site visits to prepare a state-of-the-art paper on case mix and a thorough literature review on educational costs.

In addition to these particular teaching hospital issues, the COTH Administrative Board considered and acted upon all matters brought before the AAMC Executive Council.

ORGANIZATION OF STUDENT REPRESENTATIVES

Still expanding, the OSR maintained its role as an effective student voice within the Association and as a disseminator of information to medical students across the country on issues of importance to them. This year 112 of the nation's medical schools participated, the highest number in the OSR's eight year history. At the 1978 annual meeting, 135 students from 93 schools exchanged ideas, shared concerns, and passed resolutions in support of such diverse topics as expanded research opportunities for medical students, more appropriate use of the National Board examinations, and government funding for abortion services. The well attended OSR discussion sessions dealt with student financial assistance, women in management, and career opportunities in academic medicine. "Molding of Physicians for the 1980's: Selection, Socialization or Legislation?" was

the theme of the OSR Program.

Once again the OSR Administrative Board met before each Executive Council meeting to coordinate OSR activities and to formulate recommendations on matters under consideration by the Executive Council. OSR participation on AAMC task forces and committees continued at a high level; OSR-nominated, AAMC-appointed students also now serve on the National Resident Matching Program (NRMP) Board of Directors and on the Liaison Committee on Medical Education.

The Administrative Board initiated and completed a variety of projects during the year. Longstanding efforts to increase the amount of information available to students on graduate training programs, along the lines recommended by the Transition Working Group of the Task Force on Graduate Medical Education, bore some fruit. A model questionnaire for alumni to evaluate residency programs was developed and distributed to student affairs deans in the hope that deans would institute this information-gathering method for their students. Close work with the Executive Vice President of NRMP resulted in the addition to the 1979 NRMP Directory of a grid showing some data about residency programs. Additional work is needed to expand the amount and the quality of published information, and the Administrative Board has begun a dialogue with the individuals responsible for the publication of the Directory of Residency Training Programs Accredited by the LCGME.

During 1978-79, two expanded issues of *OSR Report* were distributed to all U.S. medical students. The first was entitled "Your Funds and Your Future: a Guide to Financial Planning" and offered suggestions on budgeting, keeping track of loans and debt management. The spring *OSR Report* was part of a new effort on the part of the OSR to encourage medical student support for capitation and existing need-based financial aid programs; this issue was a guide to the health legislation process and what students can do to influence it.

Other activities initiated by the OSR Administrative Board included: 1) a membership survey to establish improved communications with and continuity in the membership; 2) collection of schools' "due process" guidelines, with the goal of developing a document describing the kinds of procedures schools rely on to insure fair treatment when questions about promotion and graduation arise; and 3) from information provided by the student affairs deans, a compilation of basic information on extramural electives.

National Policy

The past year has witnessed a remarkable change in the national policy climate. The key events include the November elections, with their strong messages to reduce taxes, curtail government expenditures, lighten the oppressive burden of government regulation, and eliminate fraud and abuse. The election results were heard "loud and clear" in Washington, where response to strong popular mandates is usually brisk. In addition, problems in foreign affairs, in the unprecedented co-existence of economic recession and rapid inflation, and in energy have assumed near crisis proportions. All of these have had direct or indirect impacts on the federal health programs of interest to the medical schools, their students, faculties and teaching hospitals.

Against this background, the Association's efforts during the year have been heavily concentrated on sustaining the flow of federal funds to our institutions and in attempting to prevent the imposition of destructive regulations. Additionally, national manpower issues, in the realm of both graduate medical education including the problems of geographic and specialty maldistribution, and also undergraduate medical education, have attracted much attention and required considerable energy on the part of deans, faculty members, students and AAMC staff.

In the legislative arena, the outcome of President Carter's efforts to control the spiraling costs of health care remains uncertain. Conflicting and weakened versions of the Administration's hospital cost containment proposals have been approved by both House and Senate Committees but final action before the Congress adjourns appears questionable. President Carter and Senator Kennedy have both recently unveiled national health insurance proposals which have been grist for their ongoing political battle. Passage of these initiatives, or any of the host of similar proposals currently being reviewed by the Congress is dubious. Other Administration actions in this area will clearly impact the Association's teaching hospitals. The executive branch's efforts to contain health care costs through regulations under sections 223 and 227 of the 1972 Social Security Act Amendments have been major foci of AAMC activity during the last year.

The Administration's first initiatives to reduce federal health expenditures—President Carter's unprecedented request that the Congress rescind a portion of the funds already appropriated in Fiscal Year 1979 for capitation, health professions students loans and the National Institutes of Health—sent a chill throughout the academic medical community. This action was predicated on economic grounds, but it also reflected the Administration's growing belief that the country would soon be faced with a surfeit of physicians and that financial aid to students preparing for careers in a lucrative profession should only be extended to those willing to dedicate their careers, at least in part, to the achievement of certain national goals, such as the alleviation of problems of specialty and geographic maldistribution of doctors.

Despite diligent efforts on the part of the Association, its constituents and other concerned health interests, and despite confident predictions to the contrary by seasoned Washington observers, the President's rescission proposals were partially accepted by the Congress.

The decision of the Congress not to fully implement the Administration's rescission messages, despite pervasive economic pressures, reflects not only a residual conviction that the education of highly qualified health professionals is an important national priority, but also a sense of obligation to prior commitments and responsiveness to importunings from the AAMC, its constituents and other health interest groups.

The Administration's budget request for Fiscal Year 1980 proved to be even more spartan and disappointing to the health professions education and biomedical research communities than last year's. The proposal eliminated all funding for capitation and health professions students loans and maintained expenditures for the National Institutes of Health at the FY 1979 level, without even an inflationary adjustment. In testimony before House and Senate Appropriations Subcommittees and during Senate oversight hearings, the Association emphasized that:

- The decision of the Office of Management and Budget to curtail or eliminate many of the health programs could certainly not have been made on the basis of the failure of these programs to achieve their objectives. Even the General Accounting Office had recently concluded that capitation funds had been well spent to achieve national purposes and were educationally valuable from the perspectives of both the federal government and the medical schools.
- Continuation of programs of financial assistance to medical students is essential if the medical profession is not to be limited to individuals from the upper socio-economic strata of our society.
- The unilateral abrogration of the capitation program would have serious deleterious consequences for the medical schools, and would most certainly lead to tuition increases, especially unpalatable to low-income and minority students. Further, loss of flexible institutional support could potentially seriously diminish the valuable diversity among institutions engaged in medical education and limit the range and scope of joint federal/academic exploration and experimentation in the pursuit of solutions to problems of public concern.
- The failure of the Administration's proposals to increase funding for the National Institutes of Health at a time when science is making gigantic strides toward the solution of problems that have heretofore proven intractable is shortsighted and potentially devastating to the future of biomedical research and to the hopes of the incurably ill.

The Association worked closely with Congress to advance the acceptance of these points of view and has urged the Members to maintain viable levels of support for medical education and biomedical research. As in past years, the AAMC's efforts and views were closely coordinated with those of the Coalition for Health Funding.

Eventually, both the House and the Senate voted to increase substantially the appropriations levels recommended by the President for health manpower and biomedical research. While the appropriations process indicated that basic understanding of and support for these programs still exist, it has also demonstrated that the Congress with its more conservative Appropriations Committees will not be as generous as in the past with the support that has created and sustained an enduring partnership between the federal government and the medical schools.

The Association has continued to explore the issues involved in renewal of health manpower legislation. At the AAMC's annual meeting last year, then HEW Secretary Joseph Califano articulated the basic tenets of the Administration's policy on renewal of federal legislation to support the education of health professionals: the nation is faced with a surfeit of physicians, severely maldistributed in terms of geographic location and specialty; the number of primary care physicians is inadequate; and physicians must be more responsive to the demographic, social and economic forces impacting health care. The strategy proposed by the Administration to respond to these policies was presaged by the rescission messages and the severe reductions in this year's budget requests.

The principal elements of the Administration's proposal call for the repeal of capitation funding, the elimination of construction grants for teaching facilities, and extension of the National Health Service Corps and NHSC scholarship program for only one year pending the outcome of a study by the Office of Management and Budget. The drastic nature of this proposal raised serious doubts among the AAMC membership as to whether it is possible for the schools to rely on the long term commitment of the federal government to education for the health professions.

Widespread opposition to the HRA/Administration proposal has grown throughout the health community and it is now probable that a re-evaluation is underway within the executive branch. The Administration failed to meet the May 15, 1979 deadline for submission of its renewal legislation and Congressional initiatives will probably not be manifest for some time. Thus, introduction of renewal legislation may be delayed until the second session of the 96th Congress.

Another serious problem in the domain of health manpower arises out of efforts in both the judicial and legislative branches to define interns and residents as employees for the purposes of the National Labor Relations Act. The Association's testimony before a House subcommittee opposing the passage of such legislation was grounded in the conviction that enactment of this proposal would destroy the individualized student-teacher relationships so vital to the education of well-trained physicians and would replace the educational and collegial spirit prevailing in teaching hospitals with an adversarial employer-employee environment.

Throughout the year the Association was actively engaged in a number of important issues affecting the medical school admission process. A serious and potentially disruptive matter related to efforts to ensure the admittance of the most highly qualified applicants to medical schools has been a growing movement, marching under the deceptive banner of "Truth in Testing." Bills requiring the public disclosure of all standardized test questions and answers, after each administration of a test, have been introduced in a number of state legislatures. Passage of such a statute in New York prompted the Association to announce its intention to discontinue the administration of the New MCAT in the state after January 1, 1980.

Even more disconcerting has been the introduction of similar legislation on the federal level. In testimony before a House subcommittee, the Association pointed out the damaging impact of such legislation on the already difficult admissions process. The AAMC will continue to monitor and oppose these unwarranted intrusions into the complex medical school admissions process by alerting legislators to the very serious and negative implications of such laws for maintaining quality in educational programs.

Another serious issue was the age discrimination regulations promulgated by HEW under the Age Discrimination Act of 1975. In testimony before the HEW Age Discrimination Task Force, the AAMC stressed that entrance into medical school has never been precluded by age; that equal consideration of all candidates is one of the central tenets of the admissions process; and that the law requires equal consideration of all applicants irrespective of age, not special consideration because of age. The Association's statement introduced data demonstrating that the reason why only a small percentage of older aspirants gain acceptance to medical school is because they lack the requisite competitive credentials, and not because admittance practices are biased. The testimony explicitly rejected the validity of the argument that "cost-benefit" considerations related to the shortened practice careers of older matriculants was a reasonable basis for discrimination in the admissions process. Despite the clarifying statements of the AAMC, the final regulations implied that medical schools have indeed discriminated on the basis of the "cost/benefit" argument. One issue of concern embodied in the regulations is the granting of private right of action to individuals, once all administrative remedies have been exhausted. The schools even if they continue their traditional nondiscriminatory practices could be subjected to law suits filed by disgruntled applicants whose ages are above average.

The Association, with the American Council of Education, filed an *amicus curiae* brief in the suit of *Cannon v. University of Chicago and Northwestern University*, in which a rejected medical school candidate alleged that she had been refused admittance on the basis of sex. The question at issue in the case was whether a private individual may sue to enforce the provisions of Title IX of the Education Amendments of 1972. The Supreme Court ruled in Cannon's favor, thus opening another door for lawsuits by disappointed applicants. An important danger implicit in the Court's decision is that admission decisions will be frequently subjected to judicial review.

The admissions policies of all health professional schools came under scrutiny from another quarter during the past year as a result of Section 504 of the 1973 Vocational Rehabilitation Act which prohibits discrimination against "otherwise qualified" handicapped individuals seeking to participate in programs receiving federal funds. In an effort to assess the implications of Section 504 and other cognate issues on the admissions process, the Association's Special Advisory Panel on Technical Standards for Medical School Admissions developed guidelines for the use of medical schools wishing to establish technical admissions standards, against which to judge an applicant's ability to fulfill the non-academic demands of medical education.

In addition, the Association was deeply concerned with a significant case, *Southeastern Community College v. Francis B. Davis*, which tested the applicability of Section 504 to the admissions practices of health professional schools. In its *amicus curiae* brief to the Supreme Court, the AAMC questioned the lower court's decision that required the school to consider Davis' application, irrespective of her disability, and mandated that the college modify its program to compensate for her handicap. In one of the few instances this term in which it has voted unanimously, the Supreme Court ruled against Davis, noting that "nothing in the language or history of Section 504 limits the freedom of an educational institution to require reasonable physical qualifications for admission to a clinical training program." Most importantly, the court interpreted the vague statutory language of Section 504 prohibiting the exclusion of "an otherwise qualified individual . . . solely by reason of his handicap" to mean that "an otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap." The Association will con-

tinue to support the access of handicapped individuals to health professional careers where it will not unduly obstruct the educational process or jeopardize patient care.

The two dominant themes on the national scene for biomedical research have been budgetary restraint and planning for the allocation of scarce resources. While the Administration has strongly advocated basic research, its actual budget request for biomedical and behavioral research has been exceedingly modest. Congressional enthusiasm for these programs also has cooled noticeably, although not as much as that of the executive branch.

The national effort to define planning principles for biomedical and behavioral research, set in motion by former Secretary Califano in the spring of 1978, culminated in a large open public forum last fall. From the testimony offered there—all, incidentally, enthusiastically in favor of sustaining and expanding the national commitment to research—the five expert panels distilled a series of reports that were then synthesized by staff into a set of recommendations to the Secretary. The IOM reviewed the NIH-prepared report sympathetically and Mr. Califano, as one of his last acts in office, approved it as the basis for development of annual five year Departmental research plans.

In parallel, Senators Kennedy and Schweiker introduced this spring S. 988, the Health Science Promotion Act of 1979, a bill placing heavy emphasis on planning through the statutory establishment of a President's Council of the Health Sciences. This body's major responsibility would be to develop each year a rolling five-year plan for biomedical and behavioral research in the form of an annual set of budget recommendations and a set of program priorities for the succeeding four years. The major thrust of the Association's testimony on the original bill was that a council be created whose principal function would be advisory, and whose advice would be directed only to the Congress.

Several initiatives undertaken by the DHEW related to the protection of human subjects of biomedical and behavioral research. Interim final regulations require that informed consent documents contain an explicit statement as to whether the sponsoring institution has in place a mechanism to compensate subjects who might be injured during the course of such research. The Department has also indicated its intention to implement, through regulation, the recommendation of its Task Force on the Compensation of Injured Research Subjects that would require all HEW grantee and contractor institutions to create and operate a mechanism to compensate injured subjects. The Association, while supportive of the HEW objectives, has been deeply concerned about the issuance of dicta when there is clearly no way for the grantee institutions to comply. Through a series of meetings and discussions, a broad-based *ad hoc* committee established to deal with this problem has concluded that so many problems exist that the imposition of a requirement for an operational program for compensation would be premature. The committee has recommended that the HEW Ethics Advisory Board be designated to review throughly the problems intrinsic to the establishment of the mechanism for compensation envisioned by the agency, and particularly the feasibility of obtaining the requisite insurance coverage.

Revision of the HEW regulations governing institutional review boards (IRB's) in accordance with the recommendations of the National Commission of the Protection of Human Subjects in Biomedical and Behavioral Research has also attracted AAMC attention. The Association has also made representations to the Food and Drug Administration on the agency's proposed regulations on IRB's as mandated by the Medical Device Amendments of 1976 and pointed out, in conjunction with the American Federation for Clinical Research, serious incompatibilities between HEW and FDA regulations that would further complicate the already difficult responsibilities of IRB's. These efforts culminated in an FDA decision to withdraw its Notice of Proposed Rulemaking and a commitment on the part of both that agency and HEW to publish reasonable and consistent regulations.

The efforts of several Federal agencies to regulate the laboratory workplace have evoked substantial concern within the academic research community. For instance, the Proposed Rule of the Occupational Safety and Health Administration (OSHA), relating to the "Identification, Classification and Regulation of Toxic Substances Posing a Potential Carcinogenic Risk," while primarily aimed at industrial workplaces, would have the unfortunate side effect of drastically increasing the costs of conducting research in academic institutions, without any discernible improvement in safety. The AAMC in conjunction with other educational associations has called OSHA's attention to the problems promulgation of these regulations could precipitate within university laboratories. A related initiative has been undertaken by the Department of Health, Education and Welfare in an effort to forestall the imposition of the troublesome OSHA regulations. The agency has published a set

of draft guidelines governing research involving the use of chemical carcinogens conducted in HEW-operated laboratories and has stated that it intends to extend their applicability to its extramural grantees and contractors. These guidelines also present serious problems for academic institutions in that they come very close to mandating relatively inflexible, costly and prescriptive standards on all laboratory work involving possible or proven carcinogens. The Association has alerted the medical schools and their teaching hospitals to the potential threat embodied in these guidelines and is attempting to persuade the agency to revise the guidelines prior to their extension to the extramural sphere.

The AAMC has devoted a major portion of its resources to a broad spectrum of other issues related to biomedical research. The biomedical research community has had serious misgivings about the content of several proposals that have been introduced and are likely to be enacted and that are ostensibly designed to curb fraudulent and abusive practices of commercial clinical laboratories and to improve the quality of "routine" clinical laboratory tests in all settings. An AAMC *ad hoc* committee assessed the potential impact of such legislation and formulated the Association's position that no legislation of this character was needed at this time. Particular concern was voiced that the legislation, as presently proposed, would not achieve its stated objective of clinical laboratory improvement; instead it would only establish a large, costly regulatory bureaucracy and further hinder progress in biomedical research.

The AAMC has worked for the passage of the Biomedical Research and Mental Health Services Extension Act of 1978, which extended the basic statutory authorities of several institutes of the NIH, established the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, extended the National Research Services Awards program, favorably modified the service-payback provisions of NRSA, and provided that four percent of NRSA funds could be awarded for short-term periods without the awardee incurring any payback obligations. The AAMC with others persuaded the Congress to place a moratorium on the taxability of NRSA research training stipends. The Association has also engaged in efforts endorsing legislation designed to insure the accessibility of medical records to scientific investigators, with the appropriate individual safeguards; advocating proposals to establish uniform government patent policies for inventions resulting from federally assisted research; supporting reformation of the Internal Revenue Code to create incentives to industry through offering income tax credits to expand its support for basic scientific research; facilitating the development of solutions to respond to the alarming decline in the number of physicians preparing for and entering clinical research and academic careers; and, under the Ethics in Government Act, adopting a new set of post-employment restrictions on former federal officials. The Association has recently reassessed its relationships with several of the federal agencies involved in the conduct and support of biomedical research. The intensification of interaction between academic medical centers on the one hand and the Food and Drug Administration and the Alcohol, Drug Abuse and Mental Health Administration on the other has prompted an increased commitment of Association resources to activities related to these two agencies. Therefore, the Association has convened *ad hoc* liaison committees to facilitate communication between the officials of these agencies and the membership of AAMC.

Important issues of major significance to the members of the AAMC await Congressional action within the next year. Chief among them are renewal of the health manpower law, the determination of policies vital to the future of biomedical research, and legislation affecting the operations of teaching hospitals. The Association in conjunction with its membership will continue to work with the Congress and the Administration to advance the nation's health through strengthening the course of biomedical research and medical education.

Working with Other Organizations

The AAMC, along with the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, and the Council on Medical Specialty Societies, has participated since 1972 as a member of the Coordinating Council on Medical Education. In the CCME representatives of the five parent organizations, the federal government, and the public have a forum to discuss medical education issues and to recommend policy statements to the parent organizations.

During the past year the Association participated in a number of new and ongoing CCME committees addressing the standard order of procedure for recognition of new specialties, the structure and function of the Liaison Committee on Graduate Medical Education, the role of the CCME in the distribution of residencies, and the impact of new medical schools and issues of increasing enrollment, size and establishment of new medical schools. A major accomplishment of the CCME was the approval for submission to parent organizations of a revision in the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education.

The Liaison Committee on Medical Education serves as the nationally recognized accrediting agency for programs of undergraduate medical education in the United States and for the medical schools in Canada.

The accreditation process provides for the medical schools a periodic, external review of assistance to their own efforts in maintaining the quality of their education programs. Survey teams are able to identify areas requiring any increased attention and indicate areas of strength as well as weakness. In the recent period of major enrollment expansion, the LCME has pointed out to certain schools that the limitations of their resources preclude expanding the enrollment without endangering the quality of the educational programs. In the other cases it has encouraged schools to make more extensive use of their resources to expand enrollment. During the decade of the sixties particularly, the LCME encouraged and assisted in the development of new medical schools; on the other hand, it has cautioned against the admission of students before an adequate and competent faculty is recruited, or before the curriculum is sufficiently planned and developed and resources gathered for its implementation.

During the 1978-79 academic year the LCME conducted accreditation surveys in addition to a number of consultation visits to universities contemplating the development or expansion of medical schools. The list of accredited schools is found in the *AAMC Directory of American Medical Education.* During the past year the LCME awarded the status of "provisional accreditation" to two new medical schools.

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

The Liaison Committee on Graduate Medical Education, established as the accrediting body for graduate medical education in 1972 by agreement of the members of the CCME, continued its efforts to improve accreditation standards and the accreditation process. Stemming from a request by the LCGME to the Coordinating Council on Medical Education to develop alternatives to having the AMA provide staff services to the LCGME and residency review committees, the CCME appointed a committee to analyze the staffing problems and make recommendations for changes. The committee has rejected proposals that the LCGME have an independent staff and is developing contract specifications for the provision of staff services which, it is hoped, will provide more efficient operation for the LCGME.

Alternatives to the present method of financing the accreditation process are being sought by the LCGME. Since its establishment, the AMA has paid half the cost for LCGME operations; the re-

mainder has been financed by a combination of revenues derived from charges to programs for review and accreditation, and an annual charge to sponsoring organizations. The LCGME has decided that no single sponsor should be responsible for a disproportionate share of the cost of the accrediting system, and various approaches to generating revenue sufficient to meet the costs of accrediting graduate medical education programs are under consideration.

The LCGME, in November 1978, approved and forwarded to the Coordinating Council, the first significant revision of the General Requirements section of the Essentials of Accredited Residencies since the Committee was established. After a six month period for comment by the sponsoring organizations, the CCME approved a version agreed to by a special conference committee, composed of representatives from both the CCME and LCGME, and forwarded it to it sponsors for ratification. If ratified, and effectively implemented, the new General Requirements will make institutions sponsoring graduate medical education programs more responsible for assuring their educational quality.

The LCGME has requested that the residency review committees revise the Special Requirements for programs in their specialties. During recent years, RRC's have developed the pattern of publishing "guides" supplementing the Special Requirements. This has caused confusion regarding standards to be met for accreditation. The revisions of the Special Requirements are to incorporate material now published in the guides, and the guides will be phased out.

The first graduate year designations established by the Council on Medical Education of the AMA prior to the LCGME's establishment, are being modified. The "categorical" and "categorical*" designations are being merged. Henceforth it is planned that specialty programs offering first graduate years to new medical school graduates will provide all the resources necessary to meet the special requirements for the specialty, including education in the complementary disciplines. These first graduate year educational experiences will be designated as "categorical." The "flexible" first graduate year will be replaced by a "transitional" year for graduates desiring a year of education and training in several disciplines before beginning specialty training in their second graduate year. "Transitional" first graduate years may be offered by institutions that sponsor two or more accredited programs and have developed local leadership and administrative policies and procedures to ensure the quality of the educational experience.

The Liaison Committee on Continuing Medical Education continued its accreditation function of institutions and organizations offering programs in continuing medical education. The LCCME has initiated review and evaluation of its policies and procedures. The Committee has become increasingly aware of the need to base continuing medical education on principles of adult learning and to relate continuing education to medical practice. Ultimately, continuing medical education must be assessed in the context of quality assurance of health care. A project initiated recently by the AAMC and the Office of Academic Affairs of the Veterans Administration aimed at developing criteria and standards for the evaluation process of continuing medical education should be helpful to the LCCME in developing its own procedures. Despite a decision by the AMA to withdraw from the LCCME, the other organizations are continuing their participation in the LCCME and restructuring its activities to compensate for AMA withdrawal.

The Coalition for Health Funding, which the Association helped form nine years ago, continues to grow in membership and influence. The usefulness of the annual Coalition analysis of the Administration's proposed health budget has been enhanced by improvements in the process for developing the Coalition recommendations and in the quality of the narrative justifying funding increases.

Working relationships with other organizations representing higher education at the university level and with professional societies continue to add to the strength of Association efforts and influence. In particular, participation in the deliberations of the Joint Health Policy Committee of the Association of American Universities/American Council on Education/National Association of State Universities and Land-Grant Colleges has facilitated a much better understanding of issues of mutual concern, especially in the field of federal legislation and regulation.

The Association shares an interest in business and administrative affairs in institutions of higher education with the National Association of College and University Business Officers. In areas where federal regulations pose administrative burdens, the AAMC has worked with the Committee on Governmental Relations to present the point of view of the nation's medical schools and teaching hospitals as a component of higher education's response. In 1978 and 1979, particular attention was given to the

revision of the Cost Principles for Educational Institutions, Circular A-21 of the federal Office of Management and Budget. Representatives of COGR, AAMC and other higher education associations met repeatedly with OMB officials in a partially successful effort to achieve more effective and practical guidelines.

As a member of the Federation of Associations of Schools of the Health Professions, the AAMC meets regularly with members representing both the educational and professional associations of eleven different health professions. This year FASHP has been concerned with student assistance proposals, budget rescissions and new requests, manpower legislation, state testing legislation and Section 504 regulations on the handicapped. The Association staff also works closely with the staff of the American Association of Dental Schools on matters of mutual concern.

With the American Council on Education the AAMC cosponsored a conference on the impact of the Bakke decision on minority admissions in graduate and professional schools. Attendees included representatives from schools of education, business, law, veterinary medicine, dentistry, osteopathic medicine, engineering, as well as graduate and undergraduate schools. The conference attendees agreed that the Supreme Court's *Bakke* decision reinforced affirmative action programs. The discussion focused on the applicant pool and financial aid, two areas believed critical to increasing opportunities in higher education for minority groups. The size of the pool of persons available at each successive level of professional training decreases for all ethnic groups, but in a greater number for underrepresented racial minority groups. Nationally, programs have been developed to deal with these educational issues in the short-run, but long-range issues, which have been neglected, need to be given immediate attention. In conclusion, the participants recommended that further discussion on issues affecting the advancement of minorities in the professions be stimulated.

As a member of the Board of Trustees of the Educational Commission for Foreign Medical Graduates, the AAMC recognizes the continuing role of medical schools and teaching hospitals in offering educational experiences to alien graduates of foreign medical schools. While several sponsor organizations of the ECFMG would favor amendments to the Immigration and Nationality Act as amended by P.L. 94-484, the Health Professions Assistance Act of 1976, the AAMC believes that more experience with the provisions of this act is necessary before any change should be considered. The ECFMG, in addition to its own examination and certification programs, administers the Visa Qualifying Examination on behalf of the National Board of Medical Examiners and, under an agreement with the United States International Communication Agency, acts as the sponsor for the Visitor Exchange Program involving graduate medical education of alien physicians.

The Association and the National Resident Matching Program work closely together to improve the process of transition between undergraduate and graduate medical education and to increase the available information about how students select their first graduate years and plan their graduate medical education. Follow-up data on all U.S. students to determine where and in which specialties they are taking their graduate education in each successive year after graduation have been collected by NRMP since 1977. These data and AAMC data will allow more effective monitoring of the career development of medical school graduates in the future.

Efforts have been made to articulate the concerns of women and to document the current status of women in medicine to concerned individuals and groups. Toward this end presentations have been made on the subject of Women in Medicine to the New York Regional American Medical Women's Association Conference on Women in Medicine, the New England group of Women Administrators in Medical Education, and to the women faculty at Rutgers Medical School. Association staff have also participated in meetings of the National Coalition for Women and Girls in Education; the Women and Health Roundtable; and Health on Wednesday, a women's governmental relations group.

Since 1970 the Association, through a cooperative agreement with the National Board of Medical Examiners, has provided a Coordinated Transfer Application System (COTRANS) as a service to its member medical schools. Through COTRANS the Association has sponsored U.S. citizens enrolled in foreign medical schools for the Part I examination of the National Boards, reducing requests for individual sponsorship by medical schools.

The Board has decided that the Part I examination, which is the first exam in its three-part exam sequence for certification for licensure, should be made available only to students enrolled in accredited U.S. medical schools. It is developing a special exam to assess knowledge in the basic medical sciences and introductory knowledge in clinical diagnosis for the purpose of evaluating other students.

This exam, which will provide a medical sciences knowledge profile, will be scored on the same fifteen point scale as the New Medical College Admission Test, and will provide a profile of knowledge and achievement in the seven basic sciences and introduction to clinical diagnosis. Scaled scores will be derived from the performance of a reference group of sophomore students educated in U.S. medical schools. A passing score will not be established.

The Association will sponsor this Medical Sciences Knowledge Profile Program. Any U.S. citizen or permanent resident alien will be able to sit for the exam. Current or past enrollment in a foreign medical school listed by the World Health Organization will not be required. The information profile will be available to U.S. medical schools to use as one criterion for evaluating applicants requesting admission with advanced standing.

Education

A review of educational initiatives within the AAMC community during this past year reveals a continuing emphasis on the related themes of evaluation and accountability. The Group on Medical Education was a forum in which a significant number of these activities found expression. The annual meeting activities of the GME included a plenary session that focused attention on the need to formalize the teaching and evaluator role of the resident. Special sessions looked at the relationship between accreditation and quality in continuing medical education, the use of the National Board certifying examinations in program evaluation, and ways of assessing "non-academic" aspects of professional development. Six of the seven GME sponsored workshops were devoted to enhancing evaluation skills ranging from the assessment of clinical performance to the use of a needs based criterion for determining quality in continuing medical education programs.

Regional GME meetings continued this thrust. The Central Region focused on the effectiveness of minority recruiting and retention efforts; the Southern Region concentrated on performance criteria at the transition points of the medical education continuum; and the Northeast Region studied the educational impact of the handicapped regulations and the pressures for new curricular accommodations to areas of specialized content.

On a related issue, the Association has participated in a growing effort to ensure that the special problems of the elderly are emphasized in both undergraduate and graduate medical education. The Association has supported efforts of the Institute on Aging of the National Institutes of Health to plan programs to accomplish this goal. During the year it convened a meeting to bring together individuals with responsibility for developing geriatric programs at their institutions and representatives of the National Institute on Aging to discuss opportunities and impediments to increasing the educational emphasis on the special medical and socioeconomic problems of the elderly. The Association, in testimony before the House Select Committee on Aging, particularly emphasized the need for resources to improve the educational viability of long-term care and nursing home facilities. The staff assisted the National Retired Teachers Association/American Association of Retired Persons in planning a conference of medical school representatives to exchange information about approaches to improving education about aging in both undergraduate and graduate medical education.

On the other side of the accountability issue, activity in state and federal government on the subject of standardized testing has increased significantly. A recurring provision of these bills requires the disclosure of questions and answers after each administration and threatens the viability of the New Medical College Admission Test (New MCAT). Ironically, the quality of the test would not be in such jeopardy were it not for the highly specialized nature of the test that resulted from the recent revisions designed to make the examination more open and relevant. Of some seven states considering testing legislation, only California and New York enacted laws. The provision of sample materials was substituted for the disclosure requirement in the final version of the California law. This did not occur in New York, with serious resulting problems remaining to be resolved there. The Association submitted formal testimony on the bills before the U.S. House of Representatives and will take all steps necessary to preserve the integrity of the New MCAT Program.

Meanwhile, the Association has entered into the second phase of an extensive interpretive study plan for the New MCAT. The effort is being directed at both the national and local levels. Construct, concurrent, and predictive validity studies are in progress using the national pool of examinees, applicants, and accepted students. At the same time AAMC is encouraging local validity studies by entering into cooperative arrangements with approximately 20% of the medical schools. The broad range of settings these schools represent will, in the long term, clarify further appropriate uses to be made of tests. A series of technical reports are planned to present data bearing on issues of general interest.

Recognizing the importance of better assessments of the credentials of candidates applying for

advanced standing, the Association has begun exploration with the National Board of Medical Examiners of an examination designed especially for that purpose. The examination is expected to yield a profile of knowledge in the seven basic medical sciences together with a measure of introductory knowledge in clinical diagnosis.

The AAMC Clinical Evaluation Project has continued and as a part of Phase I a report is in preparation. The document will reflect the concerns, practices, and recommendations of faculty engaged in the evaluation of the performance of junior clerks and residents. Numerous insights into why the current tools of evaluation are not responsive have been gleaned from over 450 departmental responses.

The Ad Hoc Committee on Continuing Medical Education was appointed by the Executive Council to review the role of the AAMC in continuing medical education. The Committee undertook several studies relative to the role of continuing education in medical practice and the potential contribution of AAMC's constituencies. A final report is under preparation.

The Educational Materials Project of the AAMC, a continuing collaborative program with the National Library of Medicine, is maintaining a peer review system for multimedia education materials entered into the AVLINE data base. The review system engages over 1,400 academic experts representing the various health professions and their specialties and subspecialties. The results of these reviews provide qualitative, evaluative descriptors of the materials and are entered into the AVLINE record. The AVLINE data base now has over 7,000 entries covering the health professions disciplines, with approximately 100 new records being added each month. AVLINE is a component of MEDLARS and is accessible for on-line searches by the National Library of Medicine. The AVLINE catalog is published quarterly and yearly. The AAMC conducts studies to review the potential impact of this information system and of the critical review process on the production and utilization of educational materials.

In order to realize further the value of the AAMC Longitudinal Study Data Base, guidelines for the sharing of selective segments of the data have been developed. The availability of the data has been promulgated by the National Center for Health Services Research and the Association is currently receiving requests from qualified investigators. Support has also been obtained from the Commonwealth Fund toward the publication of a monograph summarizing the results of the initial study.

Additional resources are in development within the GME. Two technical resource panels are preparing final reports. One is concerned with "Continuing Medical Education Needs Assessment and Evaluation" and the other treats the "Evaluation of Instructional Effectiveness For Purposes of Promotion and Tenure." The latter is expected to be of value to professional education generally. The Program Planning Committee for the Research in Medical Education Conference has instituted a system of feedback to the authors of declined submissions. This represents an attempt to increase opportunities for peer review.

Increasingly, faculty seek involvement and participation in the educational process beyond their traditional scope of activity. CAS and COTH societies and hospitals have identified over 800 individuals with interest in GME activities. This is in addition to the over 550 medical school based faculty included in the GME roster who have dedicated a significant part of their efforts to improving the educational process.

Biomedical Research

In 1978 the Association undertook a major review and reformulation of its policy in the area of biomedical and behavioral research. This review process culminated with the Executive Council's adoption of a policy that was especially timely in that within several months the federal government initiated its own activities to review several areas important to the academic research community:

- The Department of Health, Education and Welfare reviewed the principles upon which it bases its support for health research at an NIH conference. Drawing upon stated AAMC policy, Association constituents responded to each of the major topic areas and many members of the Association served on the panels established for this effort.
- A bill was introduced in the United States Senate to revise the authority for the support of the National Institutes of Health, establish new initiatives in research grant support and administration, and set up a permanent biomedical research planning body. As stated in its research policy the Association believes credible advice on biomedical and behavioral research is required for both the executive branch and the Congress and that each should establish its own advisory apparatus. The Association expressed this view to the Congress and its reservations about the usefulness of planning in the research field which is, by its nature, characterized by unpredictability.
- An inadequate budget for the support of biomedical and behavioral research was proposed for Fiscal Year 1980. This budget would have meant that the funding of investigator-initiated research grants would have reached an unprecedented low level. A coalition of organizations in which the Association played a leading role was able to marshall support in the Congress and assure adequate funding for biomedical research.

The Association saw its efforts to stabilize biomedical and behavioral research training bear significant fruit in 1979. The 1978 AAMC research policy statement pointed out the need to raise the levels of research training stipends and to assure an adequate number and distribution of physicians; Congressional response was gratifying in both areas. The Association, working with its constituent organizations, also focused attention on the serious decline in the number of physician-researchers completing research training in clinical areas. The decline in clinical investigators receiving federal research training funds became so severe that in June 1979, the Executive Council created an *ad hoc* committee to develop an overall policy for biomedical research training in the clinical areas. This committee was charged to consider how medical schools, AAMC, private and federal efforts could be coordinated to assure an adequate supply of competent clinical investigators for the future. An important part of this policy formulation focused upon the concerns of the Organization of Student Representatives that medical student research opportunities were in short supply and should be bolstered. The formulation of the policy for research training was greatly assisted by two studies of faculty characteristics and training patterns leading to academic careers, by a survey of medical student research opportunities, and by a survey of MD-PhD manpower.

The Association continued to be concerned with the changing conditions under which biomedical and behavioral research is conducted. Although laws affecting recombinant DNA research and research in clinical laboratories were not enacted by Congress, a number of other regulatory actions appeared that have important implications for the research community. Among these were proposed regulations by the Occupational Safety and Health Administration and the National Institute of Environmental Health Sciences to regulate common chemicals that have carcinogenic potential in research laboratories; the imposition of increasingly draconian accounting procedures for grants and contracts; the imposition on Institutional Review Boards for the protection of human subjects of inhibitory regulations governing research grant review and management, and regulations requiring the compensation of human subjects injured in the course of biomedical research. Each of these areas represents activities that the Association must continue in the coming year to assure a reasonable climate for the conduct of biomedical and behavioral research.

Health Care

Academic medical centers are presently exploring and implementing strategies to provide undergraduate medical students and house officers with a comprehensive learning experience in the areas of quality assurance and cost containment, issues receiving increased public attention. In the summer of 1978 the AAMC surveyed U.S. medical schools on their educational activity in these areas to determine how the AAMC could assist faculty to develop new programs. An analysis of that survey showed that 41 of the 119 U.S. medical schools incorporated education in quality assurance and cost containment into their curricula either by offering specific programs or by integrating these issues into other programs. A follow-up telephone survey late in 1978 revealed that an additional 40 institutions were planning such learning experiences for medical students and house officers. These surveys not only provided information on the number of medical schools that currently address these issues as part of the curriculum, but also revealed the diversity in the approaches taken. In a few instances distinct, block programs in quality assurance and/or cost containment have been created; in most instances the teaching of these issues is incorporated into already existing courses or programs.

To assist faculty in their program development efforts, the AAMC, under a grant from the Health Care Financing Administration and in collaboration with Johns Hopkins University, has undertaken the development of a basic text for faculty and students on quality assurance and cost containment. The text is being written by several faculty members well-experienced in quality assurance and cost containment teaching and will be ready for publication in early 1980. When completed, the text will offer a comprehensive approach adaptable to many diverse programs in quality assurance and cost containment. It will introduce the terms, concepts, and legislative history associated with quality assurance and cost containment, present the types of information and conceptual framework needed in carrying out such activities, and provide stages to be followed in conducting quality assurance and cost containment studies in practice situations. In addition, it will review existing quality assurance and cost containment programs in U.S. medical schools, suggest strategies for planning, implementing, and evaluating quality assurance and cost containment curricula, and describe new approaches to assessing quality such as technology assessment. It is anticipated that this text will be useful to faculty involved in developing educational programs, and will also provide a systematic and fundamental basis for understanding the important elements in this highly complex field.

The text will be field tested at eight academic medical centers with their immediate feedback used to revise the text prior to publication, thus ensuring that it is responsive to the needs of the users. The number of inquiries already received about the text indicates the high level of interest among faculty for this type of publication.

The AAMC hopes to develop a second text, with an accompanying faculty manual, that will provide case histories illustrating quality assurance and cost containment principles and problems. The material in this publication would be adaptable to many diverse teaching programs and would provide models to allow faculty to develop their own case histories from local data. The AAMC, in conjunction with a number of faculty experienced in the case study methodology and knowledgeable about quality and cost issues, tentatively plans to conduct a series of faculty development workshops during 1980-1981 in which both the basic text on quality assurance and cost containment and the case study text with the accompanying faculty manual will be used as educational materials.

The organization of institutional faculty practice plans remains an issue of high importance. During the past year numerous faculty have indicated an interest in establishing prepaid group practices within their institutions. The AAMC continues to facilitate an exchange of information on various models for such prepaid plans.

Faculty

During the past year the Association completed two studies examining the competitive research grant success of medical school faculty and research productivity based on published research reports.

In the first study the educational histories of medical school faculty from the AAMC Faculty Roster were matched with research grant application records from the Division of Research Grants' data base at NIH. The study showed that the educational experience having the strongest positive association with the quality of research proposals of both MD and PhD faculty was post-doctoral training. The research intensity of institutions awarding degrees and providing residency training also appeared to enhance the quality of first grant proposals by new faculty. However, after statistically accounting for the educational history of a faculty researcher, the identity of the institution from which a proposal is submitted does not have a residual effect on success in grant competition. This finding lends support to the fairness of the peer review practices of NIH.

The second study investigated the utility of computerized literature searches to assess the contributions of faculty physicians to biomedical research. The AAMC longitudinal study cohort, which entered medical school in 1956, was studied without the use of a new questionnaire. The names of cohort members were matched with names of authors in the National Library of Medicine's MEDLARS system to study the patterns of publication activity over time. Researchers who at graduation had intended to do some research published at a higher rate and in more influential journals than those who were drawn into academic medicine later in their careers. While annual publication productivity increased at a lessening rate over the period studied, the average "influence" of those articles showed a steady decline. The technique of computerized literature searches holds promise for future evaluation studies of educational programs and innovations.

The Faculty Roster System, initiated in 1965, continues to be a valuable data base with demographic, current appointment, employment history, credentials and training data for all salaried faculty at U.S. medical schools. In addition to supporting studies of faculty manpower, the system provides medical schools with faculty data in an organized and systematic manner for use in the completion of questionnaires for other organizations, the identification of alumni now serving on faculty at other schools, and production of special reports that display faculty data.

This data base has been used for a variety of manpower studies, including an annual descriptive study. These studies are supported in part by the National Institutes of Health. In 1979, "A Ten Year Comparison of Characteristics of U.S. Medical School Salaried Faculty, 1968-1978" was published. The report provides comparison data and summary information on faculty appointment characteristics, educational characteristics, employment history, and various breakdowns by sex, ethnic group, and for newly hired faculty.

As of June 1979 the Faculty Roster contained information for 52,648 faculty; an additional 27,044 records are maintained for "inactive" faculty, individuals who do not currently hold a faculty appointment. The Faculty Roster was also used to prepare an index of women and minority faculty for use by medical schools and federal agencies, in particular NIH, for recruitment purposes. Staff at AAMC can now provide, for those faculty who have consented to release data from their faculty records, specific information to aid in filling faculty positions and to assist NIH and other agencies in enlisting faculty to serve on advisory committees.

The Association's 1978-79 Report on Medical School Faculty Salaries was released in March 1979. Compensation data were presented for 117 U.S. medical schools and 28,398 filled full-time faculty positions. When compared to the 1977-78 Report, this represents an increase of nine participating schools, and there is a 20% increase in the number of faculty encompassed by the current Report. The tables present compensation averages, number reporting and percentile statistics by rank and by department for basic and clinical sciences departments. Many of the tables provide comparison data according to type of school ownership, degree held, and geographic region as well.

Students

Approximately 35,500 applicants filed more than 300,000 applications for first year places in the 1979-80 entering classes of 125 U.S. medical schools. This represents about a one percent decline in applicants from the previous year in contrast to a ten percent drop from 1977-78 to 1978-79. The quality of applicants remained high and there were increases in the number of candidates from minority racial/ethnic backgrounds.

First year enrollment rose from 16,136 in 1977-78 to 16,501 in 1978-79, while total enrollment went from 60,039 to 62,213. Although first year enrollment was at an all-time high, the two percent rate of increase was less than that experienced during all but one of the previous 11 years.

The application process was facilitated by the Early Decision Program and by the American Medical College Application Service (AMCAS). For the 1979-80 first year class, 848 students were accepted at 62 medical schools participating in the Early Decision Program. Since each of these 848 students filed only a single application rather than the average of nine applications, the processing of about 6,800 multiple applications was eliminated.

Ninety-three medical schools used AMCAS to process first year application materials for their 1979-80 entering classes and ninety-six will participate for the 1980-81 academic year. In addition to collecting and coordinating admissions data in a uniform format, AMCAS provides rosters and statistical reports to participating schools and maintains a national data bank for research projects on admissions, matriculation, and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Student Affairs Steering Committee. An article tracing the development of AMCAS from 1966 through 1978 appears on the November 1978 issue of the *Journal of Medical Education*.

The decrease in the number of applicants is also reflected in the steady reduction in the number of tests being administered in the New MCAT program. In 1978 the total number of tests administered represented a 9.2% reduction from 1977. Also, the number of examinees sitting for the spring 1979 administration was approximately 2,000 less than the spring of 1978. During the last two years slight changes have also occurred regarding the time when students take the New MCAT during their undergraduate preparation. An increasing number of students take the New MCAT for the first time during their senior year or after they have graduated from undergraduate college. Studies are underway to learn the reason for these changes and to determine if the reduction in examinees can be attributed to a general decrease in the number of those repeating the test or if the reduction is being caused by fewer individuals planning careers in medicine.

Results of the first national administration of the AAMC's Medical Student Graduation Questionnaire were sent in October 1978 to each of the 111 medical schools graduating students in 1978. The school reports compared the responses of all 7,849 graduates who completed the 33-item questionnaire with those of the respondents from their own institutions. Results of the 1979 survey will be reported this fall both to the schools and to the 1980 seniors.

Relative to widespread concerns over the growing financial problems of medical students, the AAMC continued its two-phase survey of "How Medical Students Finance Their Education." Preliminary reports of the 1977-78 survey were sent to the medical schools in the fall of 1978 and a resurvey was conducted in the spring of 1979 to assess the impact of the Health Professions Educational Assistance Act (P.L. 94-484) on medical student financing, indebtedness and career plans. Reports of the resurvey, which are expected to further document the mounting problems of student financing, will be available in late 1979.

Following dissemination of the report of the AAMC Task Force on Student Financing in the fall of 1978, ongoing efforts to improve the availability of student financial assistance have focused on five areas: increased funding levels for existing programs; improved regulations for the Health Professions Student Loan Program, the Exceptional Need Scholarship Program and the Health Education Assistance Loan Program; better financial counseling for medical students and applicants; opposition to the transfer of health related student assistance

programs to a new Department of Education; and development of proposals for improved student assistance programs for the health manpower renewal legislation. As part of this process, financial aid officers, students and AAMC staff visited for a second time with members of the White House Domestic Council.

In addition, the Association, supported by the Robert Wood Johnson Foundation, has continued to sponsor a series of financial aid workshops for schools of medicine, osteopathy and dentistry. These programs enhance the managerial and counseling skills of medical school administrators with student assistance responsibilities and provide health professions advisors with current information about the status of various federal programs and legislation related to student financial aid. The workshops also formulate recommendations for the renewal of student aid legislation.

As a result of a two-year grant from HEW, more Simulated Minority Admissions Exercise (SMAE) workshops were held this year. SMAE, developed in 1974, assists admissions committees to evaluate better noncognitive information on nontraditional applications to medical school. Since the grant began in September 1978, six regional SMAE workshops have been given with more than 200 faculty, medical school administrators and premedical advisors participating. In an effort to expand the use of SMAE, individuals in the Western and Central regions have been trained to administer the workshops; individuals in the Eastern and Southern regions will be trained over the next year.

The development of a universal graduate medical education application form is underway as the result of a recommendation of the Working Group on the Transition between Undergraduate and Graduate Medical Education of the AAMC Task Force on Graduate Medical Education. The universal application form will facilitate the transmittal of basic information from applicants to program directors. Though still in the developmental stage, the form would allow the student to send the same application to each program or to vary the information sent to each program. The program directors, after making a basic assessment of each applicant, could then request supplemental data from those in whom they were most interested.

Two research studies concerned with women medical students are near completion with the assistance of AAMC staff. The first concerns an analysis of the different acceptance rates of women at medical schools to determine, if possible, the large degree of variance among medical schools in accepting women. The second study is an effort to determine if women medical students succeed in getting their choice of specialty and residency program with the same degree of success as male medical students.

At the close of the 1978 annual meeting, the Group on Student Affairs held a day-long session entitled "GSA in the 80's" to explore student affairs-related issues and problems and potential solutions for the next ten years. Topics included "Admissions: Issues in the 80's," "Career Counseling," "Awarding the M.D. Degree: Student Rights and School Responsibilities," "Personal Counseling," and the "Student Affairs Office and the Institution: Critical Interfaces." A summary report of the session has been circulated and additional discussions of major subjects continue. The name of the GSA Committee on Financial Problems of Medical Students was changed to Committee on Student Financial Assistance and its charge expanded.

The Group on Student Affairs-Minority Affairs Section took an active part in each GSA spring regional meeting this year. Each GSA-MAS region highlighted a problem of particular concern to minority students in medical school: stress, financial aid, and the New MCAT. In addition, the Minority Affairs Officers passed resolutions encouraging the participation of students and premedical advisors in the GSA-MAS. The progress on the implementation of the recommendations of the Task Force on Minority Student Opportunities in Medicine was followed.

Women Liaison Officers participated in the four regional meetings of the Group on Student Affairs, where there were special business meetings for the Women Liaison Officers. Because of the success of this new venture, it is anticipated that Women Liaison Officers will continue to participate at future GSA regional meetings. Also, there continues to be interest among undergraduate institutions to conduct women in medicine workshops for women premedical students and health professions advisors. Frequent requests for materials are made and staff represented the Association at one of these workshops modeled after the AAMC/Wellesley experience at Barry College, Miami, Florida.

Institutional Development

In 1972 a program was initiated to strengthen the management of medical schools and academic medical centers. The effort began with an educational course in management principles and concepts designed specifically for medical school deans. The Management Advancement Program (MAP) has since expanded to include seminars for teaching hospital directors and for department of medicine chairmen.

The program has the following goals: (1) to assist institutions in the development of goals that would effectively integrate organizational and individual objectives; (2) to strengthen the decision-making and the problem-solving capabilities of academic medical center administrators; (3) to aid in the development of strategies and mechanisms that would allow medical schools and centers the flexibility to adapt more effectively and appropriately to changing environments; and (4) to analyze and better understand the function and structure of the academic medical center.

The MAP consists of several interdependent parts: an Executive Development Seminar (Phase I), an Institutional Development Seminar (Phase II), and a series of special seminars and other activities designed to provide technical assistance on specifically identified managerial issues. To date, forty seminars have been offered; participants from 122 U.S. and 12 Canadian medical schools as well as 122 hospitals have been involved.

The Executive Development Seminar for senior academic medical center administrators is a one week intensive workshop in management theory and technique. Institutional Development Seminars are designed to facilitate managerial decisionmaking on broad institutional issues. Each administrator who attends selects a group of individuals from the institution who would need to be involved in the implementation of plans under consideration. Five or six such institutional teams are invited to meet at an off-site location for several days. The format of Phase II includes lectures and team discussion sessions. Each school team is assigned an experienced management consultant who facilitates the work of the group and suggests alternative means for dealing with the management issues involved.

During the past year there were three Executive Development Seminars and one Institutional Development Seminar. A special management advancement program was offered this year for Women Liaison Officers, providing executive development for thirty women from medical schools. In addition, the first seminar on Financial Management was offered. The Financial Management Seminar enables medical school deans to review the basic principles of sound financial management and to share and discuss common problems and alternative solutions in this increasingly complex area. Sufficient interest was generated at the first Financial Management Seminar to warrant a follow-up meeting to explore further and document some of the more important issues. A second Financial Management Seminar was offered in October.

The Management Advancement Program was planned by an AAMC Steering Committee chaired by Dr. Ivan L. Bennett, Jr. This Steering Committee continues to participate in program design and monitoring. Faculty from the Sloan School of Management, the Massachusetts Institute of Technology, have played an important role in the selection and presentation of seminar content. Consulting expertise has been supplied by many individuals including faculty from the Harvard University Graduate School of Business Administration, the University of Oklahoma College of Business Administration, the Brigham Young University, the University of North Carolina School of Business Administration, and the George Washington School of Government and Business Administration. Initial financial support for the program came from the Carnegie Corporation of New York and from the Grant Foundation. Funds for MAP implementation and continuation have come primarily from the Robert Wood Johnson Foundation; in addition, conference fees help to meet expenses.

The Management Advancement Program has stimulated requests from program participants and others for the development of mechanisms that will provide ready access to management information of particular interest to academic medical center administrators. Therefore, in 1976 the Management Education Network (MEN) was designed to identify, document and transmit management information relevant to medical center settings. With support from the National Library of Medicine, *MAP Notes*, an annotated bibliography of the manage-

ment literature drawn from current periodicals and journals is prepared and distributed. Other products from the MEN project include a study guide and companion audio-visual tapes on strategic planning, a study on medical school departmental review, and a simulation model and companion study on tenure and promotion in academic medical centers.

In addition, the studies of the career patterns of medical school deans and vice presidents for health sciences and their implications for medical school leadership and management are continuing, supported by the Commonwealth Fund.

In the past year the Visiting Professor Emeritus Program with support from the National Fund for Medical Education has established a roster of active senior physicians and scientists in diverse specialty areas, and has encouraged medical schools to participate in the program whenever temporary faculty assistance is needed. These goals are being realized and visits to medical schools by emeritus professors frequently occur. As a result, the Association is now considering additional ways to utilize the talents of experienced medical educators. It is hoped that the program can continue to be a worthwhile service to the medical schools as well as providing new opportunities for senior professors to contribute in areas where their skills are greatly needed.

Teaching Hospitals

Federal regulations, especially those establishing and limiting health service payments, were the major focus of this year's teaching hospital activities. These regulations addressed long-standing AAMC concerns such as Medicare payment of physicians in teaching hospitals and limits for hospital routine service costs, as well as new areas of concerns: malpractice expense, charity care requirements for federal funds, related organizations, and mandatory hospital reporting.

Section 227 of the 1972 Social Security Amendments (P.L. 92-603) established payment provisions for physician services provided to Medicare beneficiaries in teaching hospitals. As enacted, the law provides that physicians shall be paid for professional medical and surgical services on a reasonable cost basis, through the teaching hospital, "...unless (A) such an inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients."

The Department of Health, Education and Welfare first published proposed regulations for the implementation of Section 227 in 1973. These were widely criticized by the medical education community as unworkable, inequitable, harmful to existing patterns of medical education, and punitive to physicians in teaching hospitals. Those proposed regulations were withdrawn and Congress asked the Institute of Medicine to study the payment of physicians in teaching hospitals. Although the IOM published its findings in March 1976, new regulations were not available for the scheduled implementation on October 1, 1977. Therefore, the Administrator of the Health Care Financing Administration recommended a further deferral of Section 227 implementation until September 30, 1978.

An AAMC ad hoc Committee on Medicare Section 227, appointed to review draft regulations when they became available, met to discuss major concerns with Medicare officials. In addition, comprehensive written statements of the committee's concerns, interests, and questions were furnished to Medicare officials.

The July 1978 draft regulations included many provisions that the Section 227 Committee found objectionable to teaching hospitals, medical schools, and teaching physicians. Therefore, the committee prepared a report analyzing the draft regulations that included a set of implementing principles for Section 227, a series of recommendations for critical concerns raised by the draft regulations, and a section-by-section analysis of the draft regulations. Copies of the ad hoc committee's report were distributed to all AAMC members.

In August 1978 a meeting of the Southern region of the Council of Deans discussed strategy on the pending implementation of Section 227 and the dramatic implications this would have on some medical centers if the substance of those regulations was not altered. After a thorough evaluation of the draft regulations and alternate courses of action, those at the meeting unanimously agreed that every effort should be made to repeal Section 227 and related sections of the Medicare law. The following day, medical center officials at the deans' meeting met with staffs of their Senators to explain Section 227 and its impacts. Officials from the schools present also met with the Acting Director of the Medicare Bureau and supporting staff to discuss the draft regulations.

An open meeting sponsored by the AAMC was held in September to discuss the draft regulations, the ad hoc committee's report, and the growing repeal movement. The 230 members attending the meeting were broadly representative of the Association's diverse constituency. Shortly thereafter Senator Dale Bumpers and twenty-three co-sponsors introduced an amendment to repeal Section 227. In the House of Representatives, Congressman Tim Lee Carter and twenty-two co-sponsors introduced a similar bill.

As the Congress worked toward a mid-October adjournment, the legislative calendar led Senator Bumpers to conclude that a repeal of Section 227, regardless of its merits, would not make it through the Congress. Therefore, efforts began to defer Section 227 until October 1, 1979, and to encourage HEW and its Health Care Financing Administra-

tion to work with the medical education community to develop more acceptable regulations. At the AAMC annual meeting in late October 1978, HEW Secretary Joseph Califano opened his address by announcing that HEW would accept an additional delay in implementing Section 227, study the implications of implementing the law, and provide the medical education community with an opportunity to present its views on any implementation proposal.

In January the Association held four regional workshops to review HEW's 1978 draft regulations and AAMC policy positions on them. The meetings were well attended and provided the Association's Section 227 Committee with comprehensive member comments on the regulations. To provide HCFA with clear statements of the AAMC concerns, beginning in February, the Association's ad hoc Committee on Medicare Section 227 held three half-day meetings with Medicare and HCFA representatives. However, HCFA has yet to publish new draft regulations on Section 227 and the impact of these sessions remains unknown.

Section 223 of the 1972 Social Security Amendments authorized the imposition of limitations on the costs paid for services provided under Medicare Part A coverage. Since 1974 Medicare has annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its metropolitan area or state. In March Medicare published a schedule of proposed limitations that differed significantly from the limitations proposed in prior years: the limitation on inpatient routine service costs would be replaced by a limitation on general routine operating costs that excluded capital and medical education costs; the hospital classification system would be reduced from 35 to seven categories; a wage index derived from service industry wages would be used to adjust the proportion of the limitations representing wages paid; and a "market basket" price index would be used to update historical data and to set projected ceilings.

While the methodology proposed had the potential to more closely approximate the Congressional intent for Section 223, the Association expressed its concern that the potential was not realized in the proposed regulation because the grouping scheme used to classify hospitals failed to recognize the distinctive characteristics of specialty and tertiary care hospitals; several costs that vary between hospitals were not removed; the trending factors failed to reflect the hospital labor markets and the increasing intensity of the production inputs in tertiary care hospitals; and the regulations automatically forced 20 percent of the hospitals to be arbitrarily defined as inefficient.

To minimize these deficiencies, the AAMC recommended modifications in the regulations which would provide a hospital with the option of being classified in the next nearest bed size group; require HCFA to develop a methodology recognizing the costs of serving tertiary care patients; classify tertiary care centers in rural areas with their urban counterparts; clearly exclude all medical education and capital costs included in routine hospital services; exclude energy costs; use more appropriate wage and "market basket" indices; and restore the ceilings to a less arbitrary and punitive level.

The final regulations published by HCFA, while incorporating several revisions sought by the Association, continued to place a disproportionate share of disallowed costs on COTH members. The Association is now studying data on the impact of these regulations and arranging a meeting of COTH hospitals with HCFA policymakers to discuss and protest this selective impact.

The Health Care Financing Administration has proposed that Medicare determine its share of malpractice coverage costs using a direct cost approach based on five years of claims settlement data rather than the present average cost and apportionment procedure. AAMC opposed the proposal because it violates Executive Order 12044; relies on a study using biased data and a questionable methodology; undermines the present average costs methodology; produces large variations in providers' allowable costs; has a significant inflationary impact; and violates the limitation linking Medicare and Medicaid rates. Despite substantial comments opposed to these proposed regulations, HCFA has published virtually unchanged final regulations.

While continuing to support its general position that a nationwide system of uniform cost reporting is an important requirement for the proper measurement, evaluation, and comparison of hospital costs, the Association strongly objected to an HEW Notice of Proposed Rulemaking imposing the System for Hospital Uniform Reporting as the nationwide reporting system. The Association opposed SHUR because the HEW Secretary exceeded his authority by, in effect, proposing a uniform hospital accounting system; the Notice of Proposed Rulemaking failed to comply with the administrative procedures established under Executive Order 12044; the proposal required extensive and costly record keeping in the absence of clearly defined uses for the collected data; it combined uniform reporting statements for hospital reimbursement; and it failed to fund implementing costs for the system on a dollar-for-dollar basis. The AAMC also sug-

gested that SHUR be replaced with a reporting system that used audited financial statements; consolidated cost centers; statistically reclassified entries and sampling procedures; a more liberalized concept of materiality; and a cautious approach to the application of standard units of activity measurement. Finally, while HEW proposed making all information submitted on uniform hospital reports publicly available, the Association recommended that data be considered confidential unless necessary for the efficient operation of another government agency and written consent has been obtained from the hospital.

The AAMC submitted written comments and suggestions concerning proposed regulations establishing requirements for community services and for the provision of services to persons unable to pay by health care facilities assisted under the Hill-Burton and Title XVI financial assistance programs. The Association opposed the proposed elimination of the "open door" option because the very nature of that policy makes it truly responsive to community needs. In addition, the Association noted that existing regulations required that an assisted hospital provide justification should the amount of uncompensated care provided fall substantially below the proposed obligation levels. Thus, a mechanism existed to prevent abuse without the costly expansion of contractual obligations and administrative burdens proposed by HEW. The AAMC preferred better enforcement of the existing mechanisms to the establishment of new, untested, and burdensome requirements. The Association recommended that the then current regulations be maintained and that HEW, with the assistance of providers and state program administrators, fully examine and develop, if necessary, a periodic reporting mode that would be administratively acceptable and cost effective to all parties. In addition, the AAMC called for HEW to actively support the state agencies in their efforts to investigate and determine the validity of formal complaints of program noncompliance and enforce obligation requirements where necessary. The AAMC questioned the legality of the regulations, for they proposed to expand assurance obligations beyond those agreed to at the time of receipt of the financial assistance. The AAMC held that HEW's unilateral attempt to alter, beyond legislative intent, the terms of the agreed-to assurance obligations may accurately be construed as an impairment of the original contractual agreements without the full consent of the parties involved. Unfortunately, HCFA ignored the AAMC and hospital industry comments in publishing final regulations; a suit now challenges the regulations.

Under the Medicare program, a hospital's reimbursable costs for items of service, facilities, or supplies furnished by another organization are normally the charges made by the supplying organization. However, when the hospital and the supplier are related by common ownership or control, the hospital's allowable costs are limited to the supplier's costs rather than its charges. Present Medicare policy requires the presence of significant ownership or significant control for a determination that the hospital and its supplier are related organizations. Medicare has proposed to change the definition of related organizations to replace the present concepts of significant ownership and significant control with any ownership and any control. If the proposed rules are adopted, a possible implication is that Medicare may take the position that a hospital and a medical school from which the hospital obtains services are related organizations when the hospital and the school have one or more common members on their governing boards. Once the medical school is determined to be a related organization, the hospital would be reimbursed for medical school services on the basis of the school's costs, not its charges for service unless the school provides at least 80 percent of the supplied service in "the open market." Significantly, the existence of a hospital-medical school affiliation agreement would not provide the basis for treating the two organizations as related. The AAMC has strongly recommended that Medicare withdraw the proposed regulation. The Association's opposition is based on the failure of the proposed regulation to describe adequately its proposed impact; the erroneous assumption that changing the criteria from "significant" control to "any" control eliminates subjective intermediary judgments; the extension of Medicare cost principles to related suppliers; the problem created for recruiting trustees employed in business and industry; and the absence of a definition for the term "line of business" in the related organization exception.

In addition to commenting on regulations affecting government payments, the AAMC in the past year has testified before the Subcommittee on Health of the Senate Finance Committee and the Health Subcommittees of the House Ways and Means and Interstate and Foreign Commerce Committees in opposition to the Carter Administration's legislative proposal to limit allowable hospital costs. In its testimony, the AAMC opposed the hospital cost containment proposal because it provides HEW with overly broad policy and administrative powers; it would require exorbitant administrative costs; the provision for calculating the wage component of the ceiling is inconsistent with efforts to contain costs in a labor intensive industry; the one

percent allowance for service and program improvements is far below the historical average; the bill's "anti-dumping" provision is administratively unrealistic; and the so-called "voluntary" limit is really a mandatory limit that undermines the successful voluntary program already underway.

In March 1976, when the National Labor Relations Board declared in its *Cedars-Sinai* and similar decisions that house staff are primarily students rather than employees for purposes of coverage under the National Labor Relations Act, many anticipated a reduction in Association activities on this issue. Subsequent judicial and legislative actions, stimulated by house staff unions, have not supported the original expectation. During the past year, one suit against the NLRB has continued through the courts. In that case the Physicians' National Housestaff Association alleged that the NLRB exceeded its authority in its *Cedars-Sinai* decision. Originally dismissed by a U.S. District Court on jurisdictional grounds, a three judge panel of the U.S. Court of Appeals for the District of Columbia Circuit reversed the District Court. This decision was opposed by the NLRB on the technical issue of jurisdiction and by the AAMC for substantive reasons. Therefore, when the NLRB appealed the decision to the full Court of Appeals, the AAMC sought to participate as *amicus curiae*. The U.S. Court of Appeals, citing the *amicus curiae* memoranda of the AAMC and others, issued a brief order granting the NLRB's petition for rehearing by the entire court in *Physicians National Housestaff Association v. Murphy*. The case will be scheduled for oral argument before the Court during the 1979 fall term. While normal procedure would have been to simply hold in abeyance the order of the three judge panel to the District Court, the appellate court took the unusual step of vacating that panel's judgment and opinions. This action, taken on the Court's own initiative, indicates the Court's intention that the panel's decision should not be regarded as precedent.

In August 1978 individuals from medical schools and major teaching hospitals representing over 30 academic health centers met to discuss the implications of multihospital systems for university teaching hospitals. The invitational meeting was sponsored by the Center for Multihospital Systems and Shared Services Organizations of the American Hospital Association, the Association of American Medical Colleges and the Rush Presbyterian-St. Luke's Medical Center.

The objectives of the conference were to inform academic health science centers and their teaching hospitals of the changing configuration in the structure of the hospital industry; to evaluate the potential impact of this evolving configuration on the medical schools and their teaching hospitals; and to explore the dimensions of the interface, both in the public and private sectors, on the programs of the medical schools and their teaching hospitals in the areas of levels of care of patients and in the development of medical manpower. The proceedings of the conference will be distributed to all members of the Council of Teaching Hospitals.

Communications

The Association communicates its views, studies, and reports to its constituents, interested federal representatives, and the general public through a variety of publications, news releases, news conferences, personal news media interviews, and memoranda. In addition to news stories it generates, the Association responded to more than 30 news media inquiries each week.

The major communications vehicle for keeping AAMC constituents informed is the President's *Weekly Activities Report*. This publication, which is issued 43 times a year, reaches more than 9,000 readers. It reports on AAMC activities and federal actions with a direct effect on medical education, biomedical research and health care.

During the past year ten issues of the *COTH Report* have been published. In addition to reporting Washington developments and AAMC activities of concern to COTH members, an expanded emphasis has been placed upon summarizing major government and private reports focusing on present health policy issues. Other Association newsletters include the *OSR Report*, circulated three times a year to more than 60,000 medical students; *STAR* (Student Affairs Report) printed three times a year with a circulation of 900; and the *CAS Brief*, a quarterly publication distributed to individual CAS members through the auspices of their professorial and specialty societies.

The *Journal of Medical Education* in fiscal 1979 published 1,015 pages of editorial material in the regular monthly issues, including 164 papers (85 regular articles, 65 Communications, and 14 Briefs). The *Journal* also continued to publish editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine. Monthly circulation averaged about 6,600.

The volume of manuscripts submitted to the *Journal* for consideration ran high. Papers received in 1978-79 totaled a record 450, compared with 429 and 411 the previous two years. Of the 450 articles received in 1978-79, 133 were accepted for publication, 234 were rejected, 23 were withdrawn, and 60 were pending as the year ended.

During the year special issues were devoted to minorities, medical practice plans, the three-year curriculum, and national health planning and regulation. The AAMC report, "A Policy for Biomedical and Behavioral Research," was published as a supplement.

About 31,000 copies of the annual *Medical School Admission Requirements*, 3,500 copies of the *AAMC Directory of American Medical Education*, and 6,000 copies of the *AAMC Curriculum Directory* were sold or distributed. Numerous other publications, such as directories, reports, papers, studies and proceedings were also produced and distributed by the Association.

Information Systems

In the three years since the acquisition of its own general purpose computer system, the Association has consolidated its various information systems into a centralized information resource. In the past year the Association has acquired a second computer and a number of new computer terminals, and the use of the computer system in support of Association activities has increased significantly. The Association's activities are now supported by major data systems on students, faculty, and institutions.

The American Medical College Application Service (AMCAS) System remains the primary student information system. The AMCAS system supports the Association's centralized application service by capturing data on applicants to medical schools, and linking application data with New MCAT test scores and academic record information for each applicant. Medical schools and applicants are informed of the application process through daily reports generated by the system, and the medical schools periodically receive rosters of applicants and summary statistics describing the applicants to their school and allowing for comparisons to the national applicant pool. In addition, each applicant's record is immediately available via computer terminals to Association personnel responding to telephone inquiries from applicants and medical schools.

The information in the AMCAS system also serves as the basis for special reports generated throughout the year, and provides answers to questions asked by medical school personnel or the Association staff. Finally, the information maintained in the AMCAS system is used as the basis for the Association's annual descriptive study of medical school applicants.

A number of other data systems support AMCAS and make up the medical student information system. Among these are the New MCAT Reference System containing New MCAT score information and questionnaire responses for all examinees; the College System on U.S. and Canadian colleges and universities; and the Coordinated Transfer Application System (COTRANS) recording U.S. foreign medical students applying for advanced standing in U.S. medical schools. Information on students entering medical school is maintained in the Student Record System, which follows students through their medical school careers. The Student Record System is supplemented periodically through the administration of surveys to specific groups or samples of medical students, such as the graduation questionnaire and the financial aid survey.

The Association maintains two major information systems on medical school faculty: the Faculty Roster System and the Faculty Salary Survey Information System. The Faculty Roster includes information on background, current academic appointment, employment history, education and training of all salaried faculty at U.S. medical schools. The data in the Faculty Roster are periodically reported back to the medical schools in a summary fashion enabling the schools to obtain an organized and systematic profile of their faculty. The Faculty Salary Survey System is used to amass the information obtained in the Association's annual survey of medical school faculty salaries. The information is used for the annual report on medical school faculty salaries and is available on a confidential, aggregated basis in response to special inquiries from schools.

The Association supports a number of institutional level information systems, including the Institutional Profile System which acts as a repository for information on medical schools. The information is maintained in a data base supported by a computer software package that allows immediate user retrieval of data via remote terminals. The system is used to respond to requests for data from medical schools and other interested parties, and to support a variety of research projects. There are over 14,500 items of information currently in IPS, describing many aspects of medical schools from the early 1960's through the present.

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

Additionally, institutional data on teaching hospitals are maintained by the Association. The Association's program of teaching hospital surveys combines four recurring surveys with special issue-oriented surveys. The annual surveys are the educational program and services survey, the house staff policy survey, the income and expense survey for university-owned hospitals, and the executive salary survey.

Data collection efforts of the Association are continuing to give attention to the status of women in academic medicine. Applicant, enrollment and faculty studies all include special analyses related to numbers of women, attrition rates, acceptance rates, academic rank, specialty choice, etc. Association staff will continue to do additional analyses in this area.

Treasurer's Report

The Association's Audit Committee met on September 5, 1979 and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1979. Meeting with the Committee were representatives of Ernst & Whinney, the Association's auditors; the Association's legal counsel; and Association staff. On September 13, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $8,281,260. Of that amount $6,688,768 (80.77%) originated from general fund sources; $377,040 (4.55%) from foundation grants; $1,153,122 (13.92%) from federal government reimbursement contracts; and $62,330 (.76%) from revolving funds.

Expenses for the year totaled $7,391,350, of which $5,655,457 (76.51%) was chargeable to the continuing activities of the Association; $401,097 (5.43%) to foundation grants; $1,153,122 (15.60%) to federal cost reimbursement contracts; $147,207 (2.0%) to Council designated reserves; and $34,467 (.46%) to revolving funds. Investment in fixed assets (net of depreciation) increased $233,951 to $677,371.

Balances in funds restricted by the grantor increased $2,293 to $370,972. After making provision for reserves in the amount of $416,918, principally for equipment acquisition and replacement and MCAT and AMCAS development, unrestricted funds available for general purposes increased $552,954 to $6,730,597, an amount equal to 91.06% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100% of the Association's operating budget. It is of continuing importance that an adequate reserve be maintained.

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
BALANCE SHEET
June 30, 1979

ASSETS

Cash		$ 14,609
Investments		
U.S. Treasury Bills & Notes	$2,083,217	
Certificate of Deposit	7,165,000	9,248,217
Accounts Receivable		1,150,200
Deposits and Prepaid Items		44,547
Equipment (Net of Depreciation)		677,371
TOTAL ASSETS		$11,134,944

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		$ 631,952
Deferred Income		1,363,059
Fund Balances		
Funds Restricted by Grantor for Special Purposes		370,972
General Funds		
Funds Restricted for Plant Investment	296,856	
Funds Restricted by Board for Special Purposes	1,064,137	
Investment in Fixed Assets	677,371	
General Purposes Fund	6,730,597	8,768,961
TOTAL LIABILITIES AND FUND BALANCES		$11,134,944

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
OPERATING STATEMENT
Fiscal Year Ended June 30, 1979

SOURCE OF FUNDS

Income	
Dues and Service Fees from Members	$1,674,177
Grants Restricted by Grantor	377,040
Cost Reimbursement Contracts	1,153,122
Special Services	3,618,429
Journal of Medical Education	82,080
Other Publications	302,843
Sundry (Interest $846,372)	1,073,569
TOTAL INCOME	$8,281,260
Reserve for Special Legal Contingencies	3,281
Reserve for CAS Service Program	11,943
Reserve for Special Studies	34,404
Reserve for Computer Equipment	175,000
Reserve for Minority Programs	62,251
Reserve for Special Task Forces	6,096
Reserve for Personal Assessment	23,231
TOTAL SOURCE OF FUNDS	$8,597,466

USE OF FUNDS

Operating Expenses	
Salaries and Wages	$3,287,152
Staff Benefits	508,447
Supplies and Services	2,807,898
Provision for Depreciation	112,253
Travel and Meetings	611,333
Loss on Disposal of Fixed Assets	64,267
TOTAL EXPENSES	$7,391,350
Increase in Investment in Fixed Assets (Net of Depreciation)	233,951
Transfer to Board Reserved Funds for Special Programs	340,000
Reserve for Replacement of Equipment	76,918
Increase in Restricted Fund Balances	2,293
Increase in General Purposes Fund	552,954
TOTAL USE OF FUNDS	$8,597,466

AAMC Membership

TYPE	1977-78	1978-79
Institutional	113	113
Provisional Institutional	11	13
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	16	17
Academic Societies	60	67
Teaching Hospitals	399	418
Corresponding	8	30
Individual	1,824	1,660
Distinguished Service	44	42
Emeritus	70	63
Contributing	6	6
Sustaining	11	15

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