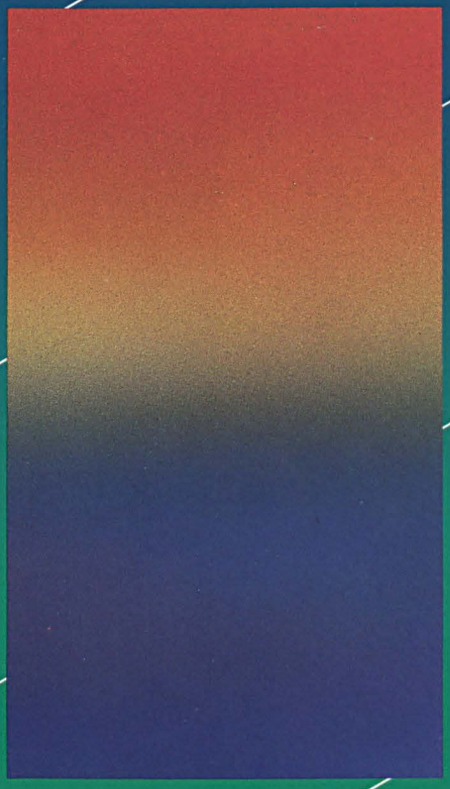
1984–1985

ANNUAL

REPORT



Association

of American

Medical Colleges

1984–85 Annual Report

Association of American Medical Colleges
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Contents

President's Message

For the last sixteen years I have been privileged to serve the Association of American Medical Colleges as its first full-time president. When I assumed this responsibility the officers charged me to implement a number of the recommendations in the reorganization plan for the membership and governance structure proposed by the Coggeshall Committee, strengthen the Association, and move its offices to Washington. The last of these charges was the most readily accomplished. Since 1970 the AAMC central offices have been in the nation's capital, and the voice of academic medicine has become known and respected as an effective advocate for vigorous biomedical and behavioral research, improved medical education, and high quality patient care.

The charge to implement an approved reorganization of the Association provided the greatest challenge. However, in keeping with the recommendations in the 1965 Coggeshall Committee report, over the last decade and a half, 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.

Some predicted that an organization composed of deans, faculty, and hospital administrators, whom they viewed as natural enemies, would soon deplete its energy and influence in exhausting internecine struggles. Instead, these groups have found it possible to work together with little friction to achieve consensus on ways to confront the challenges and opportunities facing our institutions and to establish priorities for Association programs. No group may have gotten everything that it wanted out of this collaboration. However, there has been a growing recognition by all segments of the constituency that decisions centered on the academic medical center as an institution bring greater returns than those derived from the narrow interests of any one of the groups.

The reorganization was not limited to just a restructure of the Association's governance. A conscious decision was made to emphasize the use of *ad hoc* committees, advisory panels, and task forces as necessary to consider and make recommendations on the important issues of the day rather than maintain a cumbersome and costly array of standing committees. This approach has made more effective use of the time and efforts of the constituency and staff in carrying out the work of the organization. The appointment of committees by the Association's Chairman and Executive Council and action by the Executive Council on all committee reports assure that the work of the committees is consonant with the priorities established by the Association.

Participation in Association activities and educational and training programs for professional advancement has been opened to administrators and faculty members, appointed by deans and hospital administrators, through membership in Association sponsored groups. Since the reorganization, the membership of groups has been expanded. Now professionals with interests in student and minority affairs, medical education, public affairs, alumni relations and development activities, business affairs, and institutional planning can share problems and ideas under the umbrella of an AAMC group. The total membership of the groups now numbers almost 4000.

The charge to strengthen the Association was a broad one, and has been an ongoing process that will continue into the future. It included the desire of the Executive Council to improve the financial stability of the organization by the accumulation of a reserve equal to its annual operating budget, a goal that has been approached but not yet achieved.

During my tenure the staff has grown from 79 to 155 and the annual operating budget from $2,035,711 to $11,358,696. These figures have meaning not because they reflect sustained growth, but because they now assure that the Association has more adequate resources to serve its constituency more effectively. While resources grew, membership dues and service fees have fallen from

31.5 to 26 percent of the annual budget; the remainder has come from foundation grants, gifts, government contracts, and Association programs and services. More important than these statistics has been the recruitment of a staff whose talents and abilities are recognized nationally to be of the highest caliber.

The Association's response to the needs of the constituency has been diverse, but certain programs stand out as important landmarks in the AAMC's development.

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 1986 102 schools will participate in AMCAS, which will process 303,000 applications for 33,000 students. Beyond its primary purpose, this program has also provided data that allows more extensive studies of applicants and enrolled students, now being extended by a follow-up of their residency training. The system has also permitted the development of a program to identify the use of forged documents and other irregularities in the admission process.

The Medical College Admission Test (MCAT) has been given under AAMC auspices since 1930. A major effort to revise the examination culminated with the design of a new test first administered in 1977. The Association continuously reviews the examination to assure that it meets constituent needs and to evaluate the validity and reliability of the test. As part of this process, the value of incorporating an essay question in the examination is being assessed in a pilot program with the cooperation of 30 medical schools.

One of the most effective of the Association's programs has been the management education program designed to improve the management capabilities of deans and their management teams, department chairmen, and teaching hospital administrators. The program provides both an ongoing series of seminars in basic management principles and special topic sessions developed to meet evolving needs. The latter have included management of human resources, academic medical center finances, information resources and technological innovation. More than 60 seminars have been offered since the program's inception in 1972.

In 1972, the Association took a leadership role in professional education with the appointment of a committee to develop a blueprint to assist medical schools in improving the representation of minority groups in medicine. The AAMC Office of Minority Affairs was established to assist the schools in implementing the recommendations and to monitor progress in achieving the goals established. This effort for ethnic minorities has been complemented by a special emphasis on women in medicine begun in 1976.

Recently the Association published the report of its advisory panel on the General Professional Education of the Physician and College Preparation for Medicine. This three year comprehensive review of undergraduate medical education and its interface with baccalaureate education followed on previous AAMC reviews of graduate and continuing medical education. The report has attracted international attention and has already been translated into Spanish, Japanese, Chinese and Dutch. With this study, Association committees have intensively examined the continuum of medical education over the past decade.

Other studies have addressed ethics in biomedical and behavioral research, the use of animals for research and education, characteristics of medical schools, affiliation agreements, primary care education, the teaching of quality assurance and cost containment, health maintenance organizations, medical school curricula, medical practice plans, career patterns of faculty, characteristics of medical school applicants and enrollees, evaluation of clinical performance, reimbursement mechanisms, geriatrics in medical education, the role of the library in information management, and medical informatics in education and clinical decision-making.

The Association has always viewed communication with its constituents as an important responsibility. The *Journal of Medical Education* is in its sixtieth volume and over 600 issues of a *Weekly Activities Report* have been distributed. This report keeps members current on both Association programs and other important activities on the national scene. Other publications include the *COTH Report*, the *Student Affairs Reporter* and the *OSR Report*. More detailed information has been provided by the more than 900 memoranda sent to members of the councils since 1969.

Another major activity has been the collection and analysis of information on AAMC members and their characteristics. During this period the Association established its own com-

puter center with a capable professional staff. The Institutional Profile System, operational since 1972, contains 33,000 variables from 132 sources. The Faculty Roster includes information on 112,000 individuals who have served on medical school faculties in the last two decades. The new Student and Applicant Information Management System records information on 680,000 individuals.

One of the Association's strengths has been its ability to work cooperatively with other organizations. The Association has been instrumental in the development of a number of coalitions which have worked together over time to achieve agreement on issues like federal funding for education, research and reimbursement for medical care. It has expanded its joint efforts with the American Medical Association to accredit medical education begun in 1942 to include participation with other organizations in accrediting graduate medical education and continuing medical education.

Legal interventions have increasingly become a part of our armamentarium for making our views known. The Association had a signal success during the Nixon Administration when its suit resulted in the release of $225 million in impounded research funds. Currently the Association is engaged in legal actions to protect the integrity of the MCAT, to challenge regulations on medical treatment of severely handicapped infants, to protect physician-patient privilege, and to defend the right of the faculty to make decisions about students' academic progress.

One reason for the Association's move to Washington was to add our voice to public policy making. The Association routinely testifies at congressional hearings—45 times in the past 3 years—and comments on pending legislation and regulations. Dealing with Capitol Hill has become increasingly complex because of the turnover of membership, the expansion of congressional staff, and an increased tendency of Congress to use the legislative process to effect change and to prescribe details for administration of its views. As an adopted Virginian, I have come very much to admire Thomas Jefferson, who in his autobiography had this comment on Congress, "That one hundred and fifty lawyers should do business together ought not to be expected." Surely Mr. Jefferson would blanch at the thought of today's 212 congressional lawyers.

There have been many changes in the Association since I first became president, and many others will follow. To quote Mr. Jefferson again, "...laws and institutions must go hand in hand with the progress of the human mind...as new discoveries are made, new truths discovered...with the change of circumstances, institutions must advance also to keep pace with the times." As change is considered, it is important that we not merely react and accommodate passively to changes occurring in society, for we have a responsibility to use our special resources to help define and implement new efforts that will strengthen and improve our society. One thing I hope will never change is the willingness of all within academic medicine to work together to overcome parochial interests in favor for a broad view to achieve our missions in education, research, and patient care. The friendship, support, and assistance that I have known from my colleagues in academic medicine are the most important legacies that I can bequeath to my successor.

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

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Chairman-Elect
Virginia V. Weldon

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Robert M. Heyssel

President
John A. D. Cooper

Council of Academic Societies

David H. Cohen
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Distinguished Service Member

Charles C. Sprague

Council of Deans

L. Thompson Bowles
Arnold L. Brown
William Butler
D. Kay Clawson
Robert Daniels
Louis J. Kettel
Richard H. Moy
John Naughton
Edward J. Stemmler

Council of Teaching Hospitals

J. Robert Buchanan
Sheldon S. King
Haynes Rice
C. Thomas Smith

Organization of Student Representatives

Richard Peters
Ricardo Sanchez

Executive Committee

Chairman
Richard Janeway

Chairman-Elect
Virginia V. Weldon

President
John A. D. Cooper

Chairman-Elect Council of Academic Societies
David H. Cohen

Chairman Council of Deans
Arnold L. Brown

Chairman Council of Teaching Hospitals
Sheldon S. King

The Councils

EXECUTIVE COUNCIL

The Association's Executive Council meets four times a year to consider policy matters relating to medical education, biomedical and behavioral research, and the delivery of medical care. Issues are referred by member institutions and organizations and from the constituent councils. Policy matters considered by the Executive Council are first reviewed by the Administrative Boards of the constituent councils for discussion and recommendation before final action.

Newly elected officers and senior staff of the Association held a retreat in December at Graylyn Conference Center in Winston–Salem, North Carolina. Primary attention was given to reviewing papers on future challenges and directions for the Association and its Council of Deans, Council of Teaching Hospitals, and Council of Academic Societies. Also discussed was an array of programmatic activities which might be undertaken by the Association to follow up on its study on the General Professional Education of the Physician and College Preparation for Medicine. Other agenda items included proposals for educating foreign medical students and graduates, the use of animals in biomedical research and education, and membership of investor-owned hospitals in the AAMC's Council of Teaching Hospitals.

Many of the issues reviewed and debated by the Executive Council during the past year were related to the nation's biomedical and behavioral research enterprise. In particular, considerable governance council attention was devoted to a proposal from the Office of Management and Budget which would have delayed expenditure of a substantial portion of FY85 funds appropriated for the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration until later years by making multi-year grant commitments. This would have had the effect of substantially reducing the number of competing research project grants which could have been funded, and the proposal was vigorously opposed by the Executive Council.

For the past several years the Association has been troubled by the efforts of animal rights activists to limit the use of animals in biomedical and behavioral research. An Executive Council statement emphasized the importance of contributions from such research to the nation's health. The statement also recognized the responsibility of the academic medical community to assure that the use of animals in laboratory research is conducted in a judicious, responsible, and humane manner. The Executive Council also reviewed and approved a report of an *ad hoc* committee on guidelines for the use of animals in research and education. This committee was chaired by Henry Nadler, dean of Wayne State University School of Medicine and William H. Danforth, chancellor of Washington University.

Since congressional consideration of NIH reauthorization legislation was limited to repassage in an only slightly modified form of legislation vetoed in 1984, the development of new legislative strategies was not a major issue for the Council. However, the Council did reaffirm the Association's "Principles for the Support of Biomedical Research," which precluded Association endorsement of the pending legislation. The Council authorized the establishment of a new *ad hoc* committee on research policy, to be chaired by Edward N. Brandt, chancellor at the University of Maryland School of Medicine. The committee was charged with developing or reaffirming Association positions relating to research training and research manpower needs, federal support for research institutions, research funding mechanisms and levels of funding, and the goals of federal research and the role of Congress in setting science policy. As an introduction to this undertaking, the Executive Council heard a presentation from Representative Don Fuqua, chairman of the House Committee on Science and Technology, and chairman of a new congressional Science Policy Task Force.

The Institute of Medicine of the National Academy of Sciences had issued a report on "Responding to Health Needs and Scientific Opportunity:

The Organizational Structure of the National Institutes of Health." An AAMC *ad hoc* committee under the chairmanship of Robert Berliner of Yale University School of Medicine prepared a critical review of the IOM document, which was submitted to and approved by the Executive Council. The AAMC report concurred with the major thrusts of the IOM report and in most of its conclusions, although reservations were expressed about some of the recommendations. The Committee was disappointed that the report did not address increasing congressional activism in reauthorizing the NIH and a stronger statement on the preeminence and great contributions of the NIH within the national and international scientific community.

The Executive Council reaffirmed AAMC opposition to including the Public Health Service in any cabinet reorganization to create a Department of Science.

Much of the Executive Council's attention in the patient services and medical care area was focused on Medicare reimbursement policies. Strong support was given for adoption of a DRG-specific blend of an average price and a hospital-specific price. The Council accorded the highest priority to funding a DRG price formula that was cognizant of hospital specific differences. The Council also opposed arbitrary cuts in the resident-to-bed adjustment, any change or reduction in the passthrough for direct medical education costs, and any freeze in DRG prices, especially if unaccompanied by a freeze in the blend used to determine payments. The Council supported the continued opportunity for states to be granted Medicare payment waivers as long as no increased funding was required.

Throughout the year the Council discussed members' concerns that rapid changes in the health care delivery system and reimbursement mechanisms would require some repositioning by the medical schools' clinical faculty. It was feared that in many cases academic medical centers were not presently organized to compete successfully in providing medical care, and that faculty members and teaching hospitals may not have established working relationships to permit them to work together effectively in the changing medical service environment. The Council defined a role for the Association in providing a better understanding of this environment and identifying key issues which must be considered as academic medical centers developed local strategies to meet new challenges. An Association committee chaired by Edward Stemmler, dean of the University of Pennsylvania School of Medicine, was appointed to identify important issues for AAMC constituents and to propose areas where the Association could provide either temporary or permanent services centered on these issues for its members.

The Association's position on health planning was reviewed and concern was expressed that the usefulness of health planning legislation was limited because it was impossible to have all providers covered by the same legislation. The Council supported continuing the requirement of certificate of need for expanded inpatient capacity, but not for other types of capital expenditures.

The Executive Council endorsed an action plan to deal with the problems surrounding the formation of regionalized compacts for the disposal of low-level radioactive waste. Recommended actions at the federal and state levels were specified in order to assure that the medical service and research activities of AAMC member institutions were not hampered by congressional and state inability to respond to a legislative mandate to establish regional compacts for the disposal of low-level radioactive waste.

The Executive Council supported a legislative proposal for the creation of a vaccine injury compensation program in response to concerns about the growing inadequacy of immunization of children.

At the beginning of the year the Executive Council considered a number of programmatic activities to implement some of the recommendations and findings of the General Professional Education of the Physician (GPEP) project. These discussions coincided with more detailed consideration of the GPEP report by subgroups of the Administrative Boards of the Council of Academic Societies and the Council of Deans.

J. Robert Buchanan, general director of the Massachusetts General Hospital, was asked to chair an Association committee on financing graduate medical education that would make regular reports on its deliberations to the Executive Council. The introduction of several significant legislative proposals is expected to make financing of residency training one of the principal Executive Council agenda items this year.

The Executive Council had been concerned about the impact on graduate medical education of specialty board decisions to lengthen periods of training required for certification. As a result the Association sponsored an amendment to the bylaws of the American Board of Medical Specialties to require such decisions to be approved by ABMS and concerned specialties before implementation. Although the amendment was tabled, the ABMS held an invitational conference on the impact of the certification process on graduate medical education which Robert M. Heyssel, president of The Johns Hopkins Hospital, attended as the AAMC representative. The Council believed that the Association had been instrumental in stimulating professional consideration of this issue, and hoped that the more extensive impact statements required of boards considering educational changes would be a

meaningful way of monitoring the problem.

The Medical College Admission Test, its use by medical schools in their selection process, and the effects of this use on undergraduates and undergraduate institutions were the subject of substantial interest and attention by the Executive Council. The consideration and enactment by several states of so-called "truth in testing" legislation, concerns surfaced during the GPEP study, the repudiation of the test by one medical school, and the concern of others that its importance as a source of revenue to the Association precluded objective oversight by the Association led the Executive Council to authorize a new committee to review the MCAT in the context of these concerns. The committee is chaired by Sherman Mellinkoff, dean of the University of California, Los Angeles School of Medicine.

Another educational issue of concern to the Executive Council is the transition between medical school and residency training. The Council had previously sponsored efforts to encourage all specialties to participate in the National Resident Matching Program, and is now developing other efforts to deal with the "preresidency syndrome."

In its role as a parent organization, the Executive Council reviews the policy actions of a number of accrediting bodies. It gave final approval to revisions in *Functions and Structure of a Medical School* of the Liaison Committee on Medical Education. The Council also reviewed several proposed changes in the general requirements section of the essentials for accredited residencies of the Accreditation Council for Graduate Medical Education. The Executive Council approved a change relating to completion of training, but suggested alternate language in another section to ensure that the balance between medical students and residents was such that the education of both was augmented and not diluted. The Council vetoed an amendment to the general requirements charging residency program directors with assessing clinical skills of new residents during the first year of training. Instead the Council reiterated its long-standing position that the ACGME should develop a hands-on clinical skills examination by which graduates of non-LCME accredited schools could be evaluated for adequate clinical competence before entering residency training.

Discussions concerning the membership eligibility of investor-owned teaching hospitals during Executive Council meetings over the past two years culminated in a decision to recommend to the Assembly a bylaws change that would permit membership by such institutions in the Council of Teaching Hospitals if assurances were obtained from the Internal Revenue Service that this action would not threaten the 501(c)(3) status of the Association.

The Executive Council and the Executive Committee are responsible for decisions relating to AAMC participation in court cases. Considerable attention has been given to litigation in New York concerning the application of that state's test disclosure statute on the MCAT. Several years ago the Association secured a preliminary injunction against a law that would have required that the MCAT not be offered in the state. A trial on the merits of the Association's complaint in the near future will provide a final decision in the case. The Association filed an *amicus* brief in *The Regents of the University of Michigan v. Scott Ewing*. The Council hoped that the Supreme Court had accepted the case for review in order to answer definitively and in the negative the question of whether there are circumstances under which the courts might appropriately engage in a review of the actual merits of academic decisions as opposed to the process by which they are made. The Association also joined with the American Medical Association as an *amicus curiae* in two cases before the Supreme Court dealing with the constitutionality of state laws putting requirements on physicians with respect to abortions; the arguments were limited to the proper role of states in regulating physician-patient relationships in the practice of medicine, and not with the issue of abortion. With the American Hospital Association and a number of other national professional organizations, the AAMC had fought in the courts efforts by the Department of Health and Human Services to apply Section 504 of the Vocational Rehabilitation Act to medical decisions about severely handicapped infants.

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

The Executive Council, along with the Secretary-Treasurer, the Executive Committee, and the Audit Committee, exercised careful scrutiny over the Association's fiscal affairs, and approved a small expansion in the general funds budget for fiscal year 1986.

The Executive Committee convened prior to each Executive Council meeting and conducted business by conference call as necessary. During the year the Executive Committee met with William Roper, special counsel to the president for health policy, and John Cogan, associate director of the Office of Management and Budget, to discuss issues relating to biomedical research and the problems facing clinical faculties and teaching hospitals under proposed federal legislation. They also met with the Executive Committee of the Association of Academic Health Centers to exchange views on issues of mutual concern.

COUNCIL OF DEANS

Two major meetings dominated the Council of Deans activities in 1984–85. A new program session

and social event expanded the events of particular interest to deans at the Association's annual meeting in Chicago, Illinois. The Council's spring meeting was held in Scottsdale, Arizona on March 20–23. The Council's Administrative Board met quarterly to review Executive Council agenda items of significant interest to the deans and to carry on the business of the COD. More specific concerns were reviewed by sections of the deans brought together by common interests.

At the deans' annual meeting program session, Robert L. Friedlander, dean, Albany Medical College, described practice plan litigation involving his institution. Henry P. Russe, dean, Rush Medical College, reviewed experience at his institution in auditing medical education costs. An update on the impact of the implementation of the prospective payments system on teaching hospitals was presented by James Bentley, associate director of the AAMC's Department of Teaching Hospitals. The session concluded with an analysis of the cost of medical education in West Virginia presented by James Young, vice chancellor for health affairs, West Virginia Board of Regents. John E. Jones, vice president for health sciences, West Virginia University, Richard A. DeVaul, dean, West Virginia University School of Medicine, and David K. Heydinger, associate dean of academic affairs, Marshall University School of Medicine, served as a panel of commentators on the report. Discussions at the annual business meeting were devoted to primarily three issues: the Council's response to the General Professional Education of the Physician report; the Committee on Financing Graduate Medical Education; and the new challenges facing the Council of Deans and the Association. Charles Sprague, president of the University of Texas Southwestern Health Science Center at Dallas, an AAMC distinguished service member, led off the "new challenges" discussion with reflections on the history and future of the AAMC.

The Council of Deans spring meeting addressed educational and scientific issues and featured deliberations regarding future directions for the AAMC. The spring meeting was preceded by an orientation session for new deans that introduced the AAMC leadership and staff, and provided an overview of the resources and programs of the AAMC.

Responding to an expressed interest in learning about recent developments in scientific research, Hilary Koprowski, director, Wistar Institute, University of Pennsylvania, reviewed developments in the use of monoclonal antibodies in the treatment of cancer. He was followed by several presentations on medical education programs that were responsive to the spirit of the GPEP report. Ernst Knobil, director, Laboratory for Neuroendocrinology at Houston, addressed the difficult task of introducing problem-solving as a method of instruction in the basic sciences. He described one program that required students to determine, through library research, whether or not one of a list of common assertions made in medical textbooks was supported by available evidence. Knobil suggested that a single department of basic sciences within medical schools might result in better integration of basic science teaching and greater flexibility in responding to the evolution of the biomedical sciences. J. Robert Buchanan, general director, Massachusetts General Hospital, and chairman, AAMC Committee on Financing Graduate Medical Education, reported on that committee's progress. He described the various issues under consideration and the strategies being discussed; he emphasized that no clear solution had emerged. By a brief questionnaire, he solicited the deans' view on key issues before the committee. Gerald T. Perkoff, curator's professor of family medicine, University of Missouri, described the problems and prospects of teaching clinical medicine in the ambulatory setting. He stressed that successful programs would involve faculty who shared practice and research interests in the field as well as an enthusiasm for ambulatory care as a setting for clinical education. A discussion of the MCAT essay pilot project presented by four members of its advisory committee reviewed recent advances in the assessment of writing skills over the past decade and outlined the committee's deliberations concerning objectives for the project. The essay is intended to be a cognitive rather than personality assessment, one which taps thinking and organizational skills as well as language mechanics. The panel outlined a four-phase program for evaluating the pilot project. Two hours of the meeting were set aside for small group discussions, chaired by the members of the COD Administrative Board, on the future directions for the AAMC. The groups addressed the AAMC's mission, structure and governance, program priorities, external relations, the COD, CAS, and COTH issues papers, and selection of the new AAMC president.

At the business meeting, discussions centered on developments in medical student education, graduate medical education, medical licensure, and animal research issues. Frankie Trull, executive director, Foundation for Biomedical Research, described the growth of the animal rights movement and several legislative initiatives in this area. She described the resources and the developing programs of the Foundation and the newly established National Association for Biomedical Research. Ed Wolfson, chairman, Federation of State Medical Boards Commission on Foreign Medical Education, described the commission's program to develop a data base for state licensing boards on the educational programs of foreign medical schools. Various issues arising at the transition between medical school and residency education were discussed. The deans soundly rejected, as misdirected

and insufficient, a proposal of the Accreditation Council for Graduate Medical Education to amend the general requirements of the essentials of accredited residencies. It would have required individual program directors to assess the adequacy of clinical skills of enrolled residents and to remove prior to the completion of the first year those whose deficiencies could not be remediated. The deans recommended that the Executive Council reject the proposed language in favor of an approach endorsed in 1981: an independent assessment of the clinical skills of foreign medical graduates prior to their entry into residency programs.

The southern and midwest deans and the deans of community-based medical schools met during the year, and the deans of private-freestanding schools convened a special session at the COD spring meeting.

COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals held two general membership meetings in 1984–85. Thomas J. Manning, formerly a consultant with McKinsey and Company, Inc., and Richard A. Berman, executive vice president, the New York University Medical Center, were keynote speakers at the COTH general session held during the 1984 AAMC annual meeting. Manning spoke on "Strategic Planning and the Teaching Hospital: Lessons from Other Industries." Berman described and analyzed the effect of the imposition of a severity factor on reimbursement, and upon resource utilization for specific DRGs in his presentation entitled "Severity Measures: The Teaching Hospital Difference." Berman emphasized the value of using severity measures, a "fundamental tool for the effective manager," in budgeting and forecasting, in marketing and price strategies, and in promoting an effective working relationship with physicians through a refined, more precise data base.

Over 200 hospital executives met in San Francisco May 8–11 for the eighth annual COTH spring meeting. The program opened with Victor Fuchs, professor of economics, Stanford University taking a retrospective look at his 1974 book, *Who Shall Live? Health, Economics and Social Choice.* Fuchs observed that the past decade has shown that economics can contribute substantially to an understanding of health systems and hospitals, but he expressed concern that some policy-makers fail to recognize the limits of the marketplace model for care. Views of how the changing hospital environment affects physician education were presented by Harry Beaty, dean, Northwestern University Medical School, Hiram Polk, chairman of surgery, University of Louisville, and John Gronvall, deputy chief medical director, the Veterans Administration. Charles Buck, executive director, the Hospital of the University of Pennsylvania, and Frankie Trull, executive director, the Foundation for Biomedical Research, discussed issues raised by the growing animal rights movement.

One-half day was spent examining significant issues in the control and financing of graduate medical education. Steven Schroeder, chairman of the division of general internal medicine, the University of California, San Francisco, reviewed the multiple organizations and committees involved in setting the requirements for accrediting graduate medical education. W. Donald Weston, dean, Michigan State University College of Human Medicine, described a voluntary, state-wide effort to reduce the number of residency training positions. J. Robert Buchanan, general director, Massachusetts General Hospital, summarized the deliberations of the AAMC Committee on Financing Graduate Medical Education which he chairs.

Evolving relationships with investor-owned corporations were considered as James Simmons, chairman of the not-for-profit parent of Samaritan Health Service of Phoenix, described the process of considering a sale to a for-profit corporation and then deciding not to sell. Richard O'Brien, dean, Creighton University School of Medicine, discussed the sale of St. Joseph's Hospital to a for-profit corporation. Arnold LaGuardia, senior vice president and director of finance, Scripps Clinic and Research Foundation, concluded the session with a review of arrangements Scripps has with drug and manufacturing companies and a hospital management company.

The COTH Administrative Board met four times to conduct business and discuss issues of interest and importance. A policy keenly debated throughout the year was the extension of COTH membership to investor-owned, for-profit hospitals. Participation of for-profit teaching hospitals was discussed at the 1984 COTH spring meeting, the 1984 annual meeting, and a variety of other forums. In addition, the COTH Administrative Board reviewed and analyzed all aspects of the debate over this issue. During the business session that concluded the 1985 spring meeting, Sheldon King, COTH chairman and director and executive vice president, Stanford University Hospital, presented the COTH Administrative Board's recommendation that AAMC membership requirements be amended to permit for-profit hospitals to join COTH. The discussion was favorable to the recommendation.

In addition to other matters of business, the Administrative Board heard an informative presentation by Board members on the activities of the consortia to which their hospitals belong. A synopsis of the activities of the University Hospital Consortium, Associated Healthcare Systems, Consortium of Jewish Hospitals and Voluntary Hospitals of America proved particularly interesting since large numbers of COTH members belong to these organizations.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies is comprised of representatives from 79 academic and scientific societies in the biomedical field. The CAS provides a forum for the expression of medical school faculty concerns and enhances faculty participation in the formulation of national policy related to medical education, research and patient care.

The CAS convened two meetings during 1984–85. At the annual meeting in October 1984, the CAS considered the recently released report of the AAMC Project Panel on the General Professional Education of the Physician and College Preparation for Medicine. The plenary session featured David Alexander, president of Pomona College, and a member of the GPEP panel, and August Swanson, director of the AAMC Department of Academic Affairs. Dr. Swanson, project director of GPEP, provided the Council with the developmental sequence of GPEP and noted its major purposes of assessing present approaches to teaching, and encouraging discussion of the issues. He stressed that the report was not anti-science, but rather supported the development of critical analytic thinking and lifelong scientific curiosity. Dr. Alexander discussed the pervasive effects of the disjointed medical school admission requirements on undergraduate curricula. He noted the growing trend to teach to the entrance exams and expressed a preference for small group teaching and an increased use of written papers and essays. Following these two talks the members of the Council met in small groups corresponding to the major GPEP conclusions. The groups held spirited discussions about specific phrases and apparent paradoxes of the document but agreed that the report served as an agenda of issues for serious deliberation.

The annual meeting also provided an opportunity for members to discuss the issues paper entitled "Future Challenges for the Council of Academic Societies" which emanated from the 1984 CAS Spring Meeting. During that meeting Council representatives identified and defined the major challenges facing medical school faculties in the areas of education, research and clinical practice, and considered the particular governance issues of the CAS. The comprehensive issues paper was circulated to CAS members who then identified key priorities. The respondents gave the highest priority to strong advocacy for biomedical research appropriations, efforts to achieve increased funding for research training, working with departmental chairmen to increase the institutional priority for medical students' education, examining policies and initiatives for the support of junior faculty/new investigators, developing policies to balance competing interests in an atmosphere of constrained funding, examining how medical student education programs are supported, and opposing restrictions on the use of animals in research.

The basic science societies hoped that the CAS would provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences, and examine how faculty involvement in planning and implementing improvements in medical education can be enhanced. Clinicians wanted the CAS to become involved in policy issues related to faculty practice efforts and their relation to the overall academic missions of faculty and policies and funding for graduate medical education.

Following discussion of these priorities at the annual meeting, the CAS Administrative Board reviewed current activities and noted that significant activities are in progress or proposed in each of the highlighted areas. The CAS Administrative Board plans to continue and expand its involvement in these issues.

The Council's spring meeting was held in Washington, D.C. March 14–15. The plenary session addressed the issues of support for graduate education in the biomedical and behavioral sciences. Four speakers with extensive background and expertise provided the Council with a good overview and their talks were subsequently published as an AAMC monograph entitled, *Support for Graduate Education in Biomedical and Behavioral Research.*

Robert M. Bock, dean of the Graduate School, University of Wisconsin, identified five major sources of funding for predoctoral students in the life sciences at the top 50 Ph.D.-producing schools: research assistantships, teaching assistantships, research traineeships, National Science Foundation fellowships, and loans. The use of these different mechanisms varied significantly among schools and departments, and their relative merits were discussed. Postdoctoral Ph.D. education was addressed by Frank G. Standaert, chairman of pharmacology, Georgetown University School of Medicine and Dentistry. Noting that over half of all Ph.D.s now seek postdoctoral training, he characterized the training environment, trainees, support mechanisms, employment patterns, and future trends. He emphasized the variability in training length and support mechanisms which include peer-reviewed research grants, federal traineeships and fellowships, and industry and foundations. Support for the clinical subspecialty training of physician investigators was discussed by Harold J. Fallon, chairman of medicine at the Medical College of Virginia. In a study of all internal medicine fellows, the most important source of funds identified was patient care revenues, followed by VA and military fellowships, federal training grants, and professional fees. He noted that in the increasingly competitive health care marketplace, resources for support of specialty training

may contract. However, support to prepare future academic research physicians must be preserved. Doris H. Merritt, NIH research training and research resources officer, discussed the NIH effort to provide research training for clinicians through the National Research Service Award program and the advanced career development awards. She agreed on the importance of a continued federal program in producing physician investigators who can compete effectively for NIH independent investigator grants.

Council members met in small groups to discuss the challenges of recruiting and training the next generation of research scientists. The program concluded with a presentation by J. Robert Buchanan, general director, Massachusetts General Hospital and chairman of the AAMC Committee on Financing Graduate Medical Education. He noted the impetus to the Committee's formation lay in a series of proposals to reduce Medicare payments for GME and discussed the issues involved. He warned that continuing the status quo will be increasingly difficult as academic medicine is required to compete in a price-conscious environment.

The spring meeting also included an exhibit room of print and video resource materials on the use of animals in research. Produced by scientific groups and pro-research organizations in various parts of the country, the brochures and articles gave samples of what can be done to counter active animal rights organizations. Of particular interest was the AAMC video featuring excerpts from TV talk shows, "Animals as Medical Research Subjects: An Issue Engulfed in Controversy," which illustrated the strengths and weaknesses of animal spokespersons and scientist-speakers in television interviews.

The CAS Administrative Board conducts its business at quarterly meetings held prior to each Executive Council meeting. In April the Administrative Board of the CAS reviewed the GPEP report with the COD Administrative Board. The Boards attempted to identify those areas within each conclusion where a consensus could be reached on the role of the AAMC in either providing additional commentary on the GPEP report or in implementing its recommendations. The discussion was lively and illustrated the variety of opinion on the GPEP report, particularly among the academic societies. Subsequent meetings of the Board-appointed GPEP working groups have produced a commentary on the report's five conclusions.

The Association's CAS Legislative Services Program continued to assist societies desiring special legislative tracking and public policy guidance. Five societies participated in the program in 1984–85: the American Federation for Clinical Research, the American Academy of Neurology, the American Neurological Association, the Association of University Professors of Neurology, and the Child Neurology Society.

ORGANIZATION OF STUDENT REPRESENTATIVES

During 1984–85, 122 medical schools designated a student representative to the AAMC. Approximately 130 students attended the 1984 OSR annual meeting, which opened with a presentation by Mary E. Smith, former University of Miami OSR representative, on how OSR members can become effective change agents at their schools. The opening plenary session featured Quentin Young, president, Health and Medicine Policy Research Group, and Robert G. Petersdorf, dean, University of California School of Medicine, San Diego, both of whom urged students to inform themselves about the many important economic, social, and political issues impacting the practice of medicine and the delivery of health care. After its business meeting, which included remarks from John A. D. Cooper, AAMC president, and Norma Wagoner, Group on Student Affairs chairperson, the OSR identified eight topics as foci of small group discussions: methods of student evaluation, improving one's teaching abilities, career counseling, social responsibilities/patient advocacy, curricular innovations, recognition and support of individuality in medical school, student involvement in the administrative process, and preparing for clinical responsibilities. Programs were offered on "Working with Nurses and Other Health Professionals" with Ruth Purtilo, associate professor at University of Nebraska College of Medicine, Ann Lee Zercher, director of nursing services, University of Chicago, and Ann Jobe, medical student at University of Nevada, and "Skills for Success in Medicine" with John-Henry Pfifferling, director, Center for Professional Well-Being, and JoAnn Elmore, Stanford University medical student. Discussions geared to helping OSR members put GPEP to work at their schools were held, followed by the main business meeting to elect the 1984–85 OSR Administrative Board. The OSR also offered workshops on "Medicine as a Human Experience" by David Rosen, associate professor, University of Rochester, and "The Nuts and Bolts of the NRMP" by Martin Pops, UCLA associate dean, and Pamelyn Close, OSR immediate past chairperson.

In addition to considering Executive Council agenda items and nominating students to serve on committees, the 1984–85 OSR Administrative Board focused on better ways for students to communicate with the Congress in support of influencing the National Board of Medical Examiners in directions suggested by the GPEP recommendations. In conjunction with similar activities on the part of the AAMC councils to identify the issues most important to their constituents, the Board developed a paper entitled "Challenges Identified by the Organization of Student

Representatives." One of the salutary results of this self-examination was a new formulation of OSR member responsibilities; also accrued were broadened perspectives on the deficits of medical education and on the high degree of faculty/administrator/student cooperation needed to achieve improvements.

An area of continuing OSR interest is sharing information on computer-based medical education, and in March an OSR compendium of computer activity in medical education was mailed to OSR members and deans. Data for this report was obtained from a survey sent to academic deans of U.S. and Canadian medical schools requesting information about electives or required courses utilizing computers for educational purposes and about the availability of computer-assisted instruction. The report contains information on 70 institutions; and, while recognizing that the compendium is incomplete, the OSR Administrative Board is pleased to have made a beginning in this area.

The Spring 1985 issue of *OSR Report* sought to interest all medical students in the country to consider the GPEP recommendations in conjunction with their faculty and offered concrete ideas for generating interest in change. This issue also included an article on the role of medical students in the animal research debate, and the Association of Professors of Medicine provided copies of its pamphlet "Must Animals be Used in Biomedical Research?" to accompany the article. The Fall 1985 issue discussed medical student/nurse relations. It offered background on the nursing profession, nursing education, and sources of conflicts with physicians, and included suggestions to help medical students become better allies with nurses.

National Policy

The landslide reelection of President Ronald W. Reagan by the largest electoral vote in history was labeled by many within the administration as a firm public mandate to continue policies of decreasing domestic spending, lowering the tax burden, and increasing the nation's defense program. However, a rapidly emerging consensus on a new imperative—to control the burgeoning federal budget deficit—has highlighted the serious incompatibilities between traditional and new goals. How the dilemma will be resolved is far from clear.

The 99th Congress has experienced intense preoccupation with reducing federal spending, and no program appears to be immune from the budgetary ax. The Association's energies in 1985 have been spent in efforts to protect programs of crucial importance to its constituency, including funding for biomedical and behavioral research, direct and indirect costs of graduate medical education and other components of the Medicare Prospective Payment System, and health professions education assistance. Until the federal budget is brought more nearly into balance, government programs, no matter how much in the public interest, are at risk of serious funding reductions, alterations, and in some cases, outright elimination.

Despite this bleak budgetary outlook, however, the morale of the nation's biomedical and behavioral research community was revived last October by the enactment of H.R. 6028, the generous FY 1985 Labor-HHS appropriations bill. For the second consecutive year, Congress passed this appropriations bill, a feat not accomplished in the prior four fiscal years. The $100 billion measure contained substantial increases in funding for vital health programs, including an impressive $5.1 billion for the National Institutes of Health, an increase of 14 percent over FY 1984 levels and almost 13 percent above the president's FY 1985 request. Funding for research, research training, and clinical training for the three institutes at the Alcohol, Drug Abuse and Mental Health Administration totaled $351.8 million, 10.9 percent over the 1984 level and 18.3 percent above the Reagan administration's fiscal year 1985 budget request.

House and Senate conferees did not specify in the language of the appropriations bill the number of competing research grants to be funded at NIH in FY 1985, but the report language of the bill explicitly envisioned an increase in the number from the 1984 level of 5,493 to approximately 6,500. The ink had hardly dried on the appropriations law, however, when rumors circulated about an administration move to spread the funding increases over future years, rather than to expand the level of current operations. The administration proposed to obligate funds for only 4,350 conventional one-year awards and 650 multi-year awards. All funds appropriated by Congress for the latter would be "obligated," in technical terms, in FY 1985 thereby complying with the Budget and Impoundment Control Act of 1974; but those committed to forward-funded multiyear awards would reduce the need for additional appropriations in FYs 1986 and 1987.

The grants "rollback" plan, formally released in the president's FY 1986 budget documents, stirred up protest not only within the scientific community but also on Capitol Hill. Senator Lowell Weicker attacked it vigorously after receiving a response from the General Accounting Office that the proposal was indeed illegal. Representative William Natcher made it clearly known that because the money had been appropriated by Congress, he expected it to be spent. In an effort to demonstrate the angry sentiment in the House and Senate, Representative Henry Waxman and Senator Edward Kennedy introduced resolutions to restore the grant level intended by Congress. These measures, eventually subscribed to by over 200 members of Congress, were heartily endorsed in AAMC testimony.

Senator Weicker proposed to resolve the grants rollback controversy between the executive branch and Congress by adding language in the Senate FY 1985 supplemental appropriations bill mandating the award of approximately 6,000 NIH and 540 ADAMHA grants. By specifically authorizing the forward funding of between 150 and 200 competing NIH research proposals, the Senate asserted that without explicit autho-

rization, multiyear funding of NIH grants was illegal.

The FY 1985 supplemental bill passed by the House contained no language regarding the funding of NIH and ADAMHA grants. Fortunately for the research community, conferees who understood the importance to the nation of biomedical research quickly reached agreement on the grants situation, authorizing funds to support 6,200 NIH and 550 ADAMHA grants for FY 1985. Enactment of this bill represents a silver lining in an otherwise dark cloud hanging over the research community during efforts to reduce government spending. By the same token, sustaining the increase in FY 1986 promises to be a battle.

The administration's budget request for FY 1986 reflected extraordinary emphasis on deficit reduction. Reminiscent of previous budget submissions, the president's FY 1986 request would spare defense spending from cutbacks while making significant reductions in non-defense discretionary and entitlement programs. Of the total $51 billion in spending cuts sought in this budget plan, over ten percent are comprised of health spending cuts which could have substantial, adverse ramifications for the elderly, the disadvantaged, and the physically and mentally ill.

Major reductions in health spending are targeted to the Medicare program, combining legislative and regulatory proposals to effect a savings of $4.2 billion in FY 1986, allowing a mere two percent overall increase in the program. Despite estimates of a nine percent increase in the current services estimate for Medicare expenditures in FY 1985, and concomitant projections of escalating growth in the number of Medicare beneficiaries, the president's budget emphasizes a freeze for many items including DRG prices, reimbursement rates for hospitals exempt from prospective payment, payments for direct medical education, and physician fees.

The Public Health Service, historically the recipient of most of the federal discretionary health budget, also faces significant reductions in FY 1986. The administration has proposed: cuts in, or elimination of, most of the student aid or health manpower programs contained in Title IV of the Higher Education Act and Title VII of the Public Health Service Act; no additional capitalization funds for Health Professions Student Loans, a continuation into the FY 1986 budget request of a seven year trend; no funding for either the Exceptional Financial Need or Disadvantaged Assistance programs; lowering the guarantee level for the Health Education Assistance Loan program to $100 million from last year's $250 million because a perceived physician oversupply diminishes the need for medical student financial assistance; and no funds for new National Health Service Corps scholarships or for health planning.

The National Institutes of Health would suffer its first reduction since 1970 under the FY 1986 budget request. Despite the $5.1 billion FY 1985 appropriation for the NIH, the administration has requested only $4.85 billion for the agency in FY 1986, a reduction of six percent. This level of funding would also be sufficient to support only 5,000 competing research project grants, the same number the administration proposed to fund in FY 1985.

The Alcohol, Drug Abuse and Mental Health Administration would suffer much the same fate as the NIH, with a request for $311.5 million in FY 1986 for ADAMHA's research programs, a one percent reduction from FY 1985. The 583 competing grants level funded in the FY 1985 appropriations bill would be reduced to 500 in both FY 1985 and FY 1986 under a grant rollback plan similar to that proposed for NIH, resulting in an award rate for ADAMHA of around 33 percent.

The Veterans Administration, which has been spared budget cuts in prior years, now faces attempts to reduce its health care expenditures and to alter long-standing fundamental policies regarding eligibility. The President's FY 1986 budget request contained a mere 2.6 percent increase over 1985 levels for medical care, and a two percent decrease in VA research funding, despite the fact that in constant dollars, neither of these programs have been increased in eight years. Even more significant, however, are plans to slow down the growth of the VA health care system by implementing a means test for all veterans seeking nonservice-connected medical care, and requiring third-party reimbursement for insured veterans. Additional savings would be realized by drastic reductions of administrative and operational funds.

In hearings before the House and Senate Appropriations Committees, the AAMC argued that proposals for a means test and third-party reimbursement would transform the VA into a chronic care system of last resort, requiring substantial out-of-pocket expenditures for many veterans before being entitled to VA medical care. The Association expressed alarm over the proposed staffing reductions and the consequent lowering of staffing ratios, already far below standards for non-federal hospitals, and the fact that neither the medical care nor research budgets have increased in eight years. It was also argued that the long-standing and mutually-beneficial relationships between medical schools and their VA affiliated hospitals could be adversely affected if VA hospitals are transformed into chronic care facilities.

After the House and Senate approved their respective budget resolutions, the debate between conferees on a compromise package was protracted and often heated. Items of conflict in the conference in-

cluded Social Security, Medicare and Medicaid, defense spending, foreign aid, and a host of domestic issues. Politics fanned the controversy over an acceptable compromise, and resolution of differences was difficult. The final compromise, passed by the House and the Senate just before the August recess, diverges dramatically from the spending priorities contained in the president's FY 1986 budget request. It calls for a 1988 deficit of $112 billion, allows an inflation-only increase for defense spending, and spares domestic spending from much of the proposed reductions. The compromise contains no tax increases, and no major domestic programs were eliminated, causing many law-makers to question whether deficits will ever fall below the $100 billion mark. Although seven of thirteen appropriations measures were passed by the House before the August recess, many programs of interest to the AAMC may have to be funded through a continuing resolution.

Proposals to simplify the federal tax code received a great deal of attention in the 99th Congress. President Reagan's tax reform proposal contains provisions that would have a substantial and in some cases adverse impact on institutions of higher education: repeal of the tax-exempt status of industrial development bonds, extensively used by universities and teaching hospitals to generate capital for construction and renovation of facilities; limits on deductions for charitable contributions to itemizers; elimination of deductions for state and local taxes; extension of the investment tax credit for research and development for only three years and a tightening of the definition of research expenditures that would qualify under the credit; and imposition of limited taxes on employer-provided fringe benefits.

The Association and a dozen other higher education organizations joined the American Council on Education in supporting the concept of tax simplification, but cautioning against the deleterious effects on higher education of some of the president's proposals. The statement noted that institutions of higher learning would suffer if deductions for charitable contributions and for state and local taxes were repealed, and pointed out that several studies estimate that charitable giving to non-profit institutions could be reduced by $11 billion, or 17 percent.

Legislation reauthorizing several key programs of the National Institutes of Health was passed during the last week of the 98th Congress. The bill that emerged from the conference reauthorized expired NIH authorities for fiscal years 1986 and 1987 only, provided generous ceilings for the NCI and NHLBI, and recodified the Public Health Service Act, a major objective of Representative Henry Waxman. It also contained numerous new statutory directives that the AAMC had criticized as allowing an unwise degree of congressional intrusion into the operation of the NIH and as contrary to the Association's preference for simple renewal of existing authorities.

Some of the bill's more objectionable items would have: created new nursing and arthritis institutes; imposed new restrictions on the use of animals in research; established new statutory restrictions on fetal research and imposed a 36-month moratorium on the use of a waiver for this research; added requirements that institutions establish procedures for handling reports of scientific fraud; directed institute advisory councils to include non-biomedical scientists as part of the scientific representation on the council; required peer-review of intramural research; and mandated NIH support for specific types of research, research centers, advisory committees, interagency committees and other commissions.

President Reagan's pocket veto of this bill in early November was accompanied by a message charging that it "would impede the progress of this important health activity by creating unnecessary, expensive new organizational entities" and that it mandated "overly specific requirements for the management of research that place undue constraints on executive branch authorities and function." The president's views were entirely compatible with those of the AAMC.

The Congress was clearly frustrated by the veto of legislation that was a product of extensive negotiation and compromise. The House in June passed H.R. 2409, a bill virtually identical to the vetoed bill except that it contains a reauthorization of only one year for NIH; the Senate followed suit with the introduction of S. 1309. The Senate bill differs from the House version in that it reauthorizes expired NIH programs for three years, contains funding ceilings sufficient to support 6,000 competing project grants for FYs 1986–1988, and maintains current services support for other programs. Moreover, the Senate version does not provide for the creation of a nursing institute.

The conference to iron out the differences between the two measures is not likely to be free from controversy. The threat of another presidential veto also remains very real, despite numerous minor changes made in the new legislation to appease the administration.

A new twist in the NIH reauthorization debate arose early this spring when the administration circulated its own draft of a three-year NIH reauthorization bill containing no additional mandates to NIH's authorities and no recodification provisions for the Public Health Service Act. The bill would eliminate the two current authorization ceilings for NCI and NHLBI and seven relatively small line-items within NIADDK; thus these programs would use funding authority pro-

vided in Section 301. While this outcome would be the best possible from the Association's point of view, it would likely elicit strong opposition from the constituency groups traditionally aligned with these institutes.

Health manpower legislation, passed by Congress in October 1984 and supported by the AAMC, was also pocket-vetoed, to the chagrin of the health professions education community. The vetoed H.R. 2574 proposed a three-year reauthorization of the health manpower authorities in Title VII of the Public Health Service Act at levels generally higher than FY 1984 levels, made several changes to the HEAL and HPSL programs, and provided authorizations for nurse training and research and the National Health Service Corps program.

The Administration, which apparently favors a single omnibus authorization of all health professions education authorities, opposed the compromise manpower bill primarily because of the authorization ceilings. Stating that H.R. 2574 was seriously flawed, the veto message argued that the legislation would "continue to increase obsolete federal subsidies to health professions students and would maintain the static and rigid categorical framework to deliver such aid."

Despite House and Senate agreement on the need for swift renewal of health manpower programs, particularly in light of the proposed elimination of funding for Title VII in the FY 1986 budget request, action in the 99th Congress has proceeded slowly. In late April, Representative Henry Waxman introduced H.R. 2251, a bill nearly identical to the vetoed manpower proposal of the last Congress. During hearings the AAMC argued that student assistance continues to be in the public interest and would be necessary even if enrollments were reduced. The sharp declines in HPSL delinquency rates at medical schools were pointed out, and suggestions made for statutory changes to further improve the management of the HEAL program. The AAMC also expressed support for higher HEAL loan guarantee ceilings to meet growing borrower demand.

Committee amendments to H.R. 2251, renamed H.R. 2410, reduced the interest rate on HEAL loans to T-bills plus three percent while eliminating the provision allowing only simple interest to be charged on HEAL loans for up to six years; allowed unused HEAL lending authority to be carried forward into succeeding years; and required HEAL loans to be disbursed jointly to institutions and borrowers. The bill passed the House in July.

Senators Orrin Hatch and Edward Kennedy introduced a companion bill S. 1283 that would renew Title VII programs for three years. It contains authorization ceilings ten percent below the aggregate appropriations levels for Title VII, and freezes each line-item at its FY 1986 level for the two succeeding years. The bill continues the HPSL program but without new capital. The Senate measure also incorporates the House provisions on maximum interest for HEAL loans and on allowing unused HEAL authority to be carried over into succeeding years. S. 1283 was passed by the Senate with an amendment to increase the maximum HEAL insurance premium from two to six percent. This premium would be charged only on the original principal of a loan, not on each year's outstanding principal, as in current law.

It remains to be seen whether the conference health manpower bill will be vetoed a second time by President Reagan. The administration's opposition to the bill, which is already a matter of public record, will likely be fueled by the HHS Inspector General report released last March that identified "serious, interrelated deficiencies in the HEAL program." As was the case last year, the Association believes that the bill likely to emerge from conference is as favorable as is possible under the current political and economic conditions, and hopes that the president will approve it.

Medical students also rely on education assistance programs authorized in Title IV of the Higher Education Act. They expire at the end of the current fiscal year, but can be extended automatically for another year under the General Education Procedures Act. The AAMC has joined with other higher education groups in proposing recommendations for the reauthorization of this act, suggesting that annual graduate and professional student borrowing maximums be increased to $8,000, with a $40,000 cumulative limit for Guaranteed Student Loans, while eliminating the current five percent loan origination fee. Also recommended were: an automatic fifteen year repayment schedule for students with GSL debts exceeding $25,000; reauthorization of loan consolidation with repayment schedules and interest rates linked to a student's indebtedness; and creation of a campus-based grant program, with funds earmarked to needy students in their first two years of study.

The Association has been increasingly involved in the push to enact consent language for regional low-level radioactive waste disposal compacts. No action was taken on this issue during the 98th Congress, and as the January 1, 1986 deadline—the date by which current law allows those compact regions with operating disposal sites to deny out-of-region generators access to their sites—draws near, pressure continues to mount in Congress to approve submitted compacts.

Representative Morris Udall, the major congressional leader on this issue, introduced compact consent legislation (H.R. 1083) in January, that, as marked

up by subcommittee in July, requires the three compacts with operating sites to offer access to their sites to out-of-region generators through 1992 as a precondition for consent of their compacts. However, those compacts without sites would have to make specific progress toward establishing their own sites to gain this continued access. Nuclear-powered utilities would be required to reduce the volume of waste they ship to these three sites, but health-related generators, including medical schools and hospitals, would not. H.R. 1083 must be approved by the Interior Committee and the Energy and Commerce Committee before it can be taken to the House floor.

Another phenomenon of increasing concern to the Association is the growth of the animal rights movement in membership, resources, sophistication, and political clout. The debate over the propriety of using animals as experimental subjects has escalated significantly at the national, state and local levels, posing a threat to their continued availability and use in research and education. The goals of the animal rights movement range from promoting improved care for laboratory animals to prohibition on their use in research entirely. Some extremists are increasingly resorting to terrorist tactics—such as laboratory break-ins, theft and destruction of research property, threats against scientists and their families, and occupation of government buildings such as the NIH—to make their viewpoints known to the public.

Constant pressure exerted by the animal rights movement to strengthen guidelines governing the use of animals in federally-funded research projects prompted the National Institutes of Health to conduct an in-depth two-year study of its animal care guidelines. The review resulted in a revised PHS policy on humane care and use of laboratory animals by awardee institutions, released in May. The new policy adds numerous requirements for animal welfare assurances and mandates that each institution designate an official who is ultimately responsible for the animal care program. The role, responsibilities and membership of the institutional animal care and use committees are more clearly defined and significantly expanded to involve them in virtually all aspects of PHS-funded animal research activities. The new policy will likely have a positive impact on animal care and use during the conduct of biomedical and behavioral research in research institutions.

Promulgation of this new policy has not tempered the crusade of many animals rights activists to eliminate any use of animals in research. Several testified before the House and Senate Appropriations Committees during consideration of the FY 1986 NIH budget, arguing specifically against continued federal funding for particular research projects. The fact that the viewpoints of animal rights activists are being considered in Congress during the development of funding decisions is illustrative of the increasing persuasiveness with which this group conveys its views.

The NIH reauthorization bill is the only legislation containing animal provisions to see action in the 99th Congress. This attenuated version of previously severely restrictive legislation is now relatively consistent with the provisions in the new PHS animal policy, and should not create major problems for research institutions.

Representative George Brown has again led the effort in the 99th Congress to find a compromise bill to strengthen the Animal Welfare Act. H.R. 2653 contains new requirements and provisions that far exceed the requirements in the new PHS policy. The AAMC has objected to the increased authority that would be bestowed upon the Secretary of Agriculture to promulgate new standards and prescriptions on specific research procedures, arguing that it could promote substantial government interference in the conduct of scientific research. Representative Brown and Senator Robert Dole, who introduced an identical Senate bill, have indicated their determination to enact their animal legislation during this Congress, despite repeated assertions from the scientific community that it is unwarranted.

Another measure of great concern to the Association is H.R. 1145, legislation reintroduced by Representative Robert Torricelli that would create a National Center for Research Accountability to prevent unnecessary duplication of research by conducting full-text searches of the world's literature to determine whether the research proposed in each federal grant application has ever been done. The AAMC argued that the bill is based on the inaccurate assumption that duplication of research is unnecessary and wasteful, and that it undermines the peer-review process at funding agencies where grant applications are carefully evaluated by experts who offer added protection against unnecessary or unintentional duplicative research. Though the Torricelli bill now has over 50 sponsors, it is doubtful that it will be acted on in this Congress because of its far-reaching implications and its expensive price tag of almost $5 billion.

The Association was asked by the Office of Technology Assessment to participate in its study on the use of alternatives to animals in research, education and testing by providing specific data on the use of animals for teaching purposes. A sample of medical schools revealed a reduction over the decade in the number of animals used because of the increasing costs associated with such use and the development of valid alternatives. The study also showed that alternative methods have not replaced animal use entirely, but

served primarily as adjuncts to animal models in the laboratories.

A new focus of interest has emerged in the 99th Congress with the introduction by Representative Don Fuqua of H.R. 2823, legislation to create a set-aside from the university research and development budgets of the six largest federal research agencies in order to fund facilities construction and renovation projects. Beginning with a straight line-item authorization for facilities projects in FY 1987, the first year of the ten year program, the proposal would set-aside ten percent of university research development budgets for facilities projects. Under the proposal, fifteen percent of the set-aside would be further earmarked for emerging universities and colleges. In years in which federal funds for university R&D drop, the facilities program would bear the entire brunt of the cut until it is exhausted. The bill also sets broad guidelines and criteria for funding each agency's university construction programs. The AAMC will likely be a major player in the ensuing discussion on this legislation. Broad questions remain to be answered, however, regarding the facilities needs of the country, and the appropriate funding mechanism for providing improvements for our nation's research facilities.

The General Accounting Office has undertaken a follow-up of its 1980 study of U.S. citizens studying medicine abroad. At a preliminary conference held in June, the Association pointed out that the for-profit schools in which 75 percent or more of U.S. citizens studying medicine abroad are enrolled are significantly subsidized by U.S. governmental agencies and private institutions. These subsidies include guaranteed student loans, the provision of clinical education in U.S. hospitals without charge or at a fraction of its true cost, and the provision of residency training to U.S. foreign medical graduates. It was recommended that these subsidies be terminated by not allowing guaranteed student loan eligibility for students enrolled in foreign medical schools where more than 25 percent of the students are not citizens of the country in which the school is located; by denying licensure to graduates of medical schools that do not provide the full program of education (including clinical education) in the countries in which they are located, and by not supporting the graduate medical education of foreign medical graduates through Medicare.

The Association's clear challenge for the coming year is to continue to work to ensure that its high priorities—a vigorous biomedical and behavioral research program, student financial assistance, and health care programs that are compatible with sound medical education—are maintained. In an atmosphere where no program will be free from budgetary scrutiny, this task will be difficult indeed.

Working with Other Organizations

The Council for Medical Affairs—composed of the top elected officials and chief executive officers of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Council of Medical Specialty Societies, and the AAMC—continues to act as a forum for the exchange of ideas by these important private sector health organizations. Among the topics considered during the past year were federal recognition of self-designated specialty boards, financing graduate medical education, clerkships in U.S. hospitals for foreign medical graduates, falsification of physician credentials from certain foreign medical schools, proposed legislation on fraudulent medical credentials, and problems of cheating on and security of national medical examinations.

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

The accrediting process assists schools of medicine to attain prevailing standards of education and provides assurance to society and the medical profession that graduates of accredited schools meet reasonable and appropriate national standards, to students that they will receive a useful and valid educational experience, and to institutions that their efforts and expenditures are suitable allocated. Survey teams provide a periodic external review, identifying areas requiring increased attention, and identify areas of strength as well as weakness. In 1985 new standards for accreditation of M.D. degree programs were adopted by the LCME and approved by its sponsors. These new standards defined in *Functions and Structure of a Medical School,* will allow the LCME to continue its role in maintaining high standards in medical education.

Through the efforts of its professional staff members the LCME provides factual information, advice, and formal and informal consultation visits to developing schools. Since 1960 forty-one new medical schools in the United States and four in Canada have been accredited by the LCME. This consultation service is also available to fully developed medical schools desiring assistance in the evaluation of their academic program.

In 1985 there are 127 accredited medical schools in the United States, of which one has a two-year program in the basic medical sciences. One has not graduated its first class and consequently is provisionally accredited. Additional medical schools are in various stages of planning and organization. The list of accredited schools is published in the *AAMC Directory of American Medical Education.*

A number of proprietary medical schools have been established or proposed for development in Mexico and various countries in the Caribbean area. These entrepreneurial schools seem to share the common purpose of recruiting U.S. citizens. The exposure of a scheme to sell false diplomas and credentials for two schools in the Dominican Republic has brought increased review by licensure bodies of all foreign medical graduates and brought the indictment and conviction of the individuals and increasing suspicion of proprietary schools. Moreover, the percentage of foreign medical graduates receiving residency appointments is decreasing, due in part to the fact that the number of students graduating from U.S. medical schools more closely matches the number of residency positions available. Thus, M.D. degree graduates from foreign medical schools of unknown quality may have increased difficulty in securing the residency training required by most states for medical licensure.

The Accreditation Council for Graduate Medical Education continued to refine its policies and procedures for the accreditation of graduate medical education programs. A review of the procedures for

programs to appeal adverse decisions by residency review committees is underway. A chief concern is the protracted time the present appeals procedures permit a program to remain in accredited status after an RRC has decided accreditation should be withdrawn.

The ACGME, in order to increase the opportunity for broad discussion and comment, will, in the future, forward all proposed changes in special requirements to its sponsoring organizations at the same time that they are forwarded to residency review committee sponsors. Changes in educational requirements that impinge on institutional resources are of great concern to program directors and teaching hospitals administrators. This new procedure will allow more time for input to the RRCs before the ACGME grants final approval to changes in special requirements.

The Association ratified a change in the general requirements of the essentials of accredited residencies that cautions program directors to limit the number of medical students for whom residents are responsible to that which will augment both the students' and residents' education. The AAMC did not ratify a change that would have substituted an assessment of residents' clinical skills by program directors during the first graduate year for a hands-on examination of foreign medical graduates prior to entry.

The Accreditation Council for Continuing Medical Education, through its Accreditation Review committee, continued its vigorous review of CME programs. During the past year the Committee for Review and Recognition initiated the review process for the recognition of state medical societies and anticipates that the first review cycle of all states will be completed in 1987. The ACCME continues its efforts to develop guidelines for judging the quality of enduring CME materials such as computer-assisted and videotape programs.

At its 1985 meeting the National Board of Medical Examiners adopted a plan to modify Parts I and II of the Board's certification examination sequence. The change is directed toward making these examinations comprehensive assessments of students' readiness to proceed in their medical education and to continue their learning after graduation. The disciplinary composition of the examinations will be more flexible, and rather than providing students a score for each subtest, a single overall score will be reported. Medical schools will receive reports on the aggregate scores of their students in each discipline. Some have expressed concern that this development will cause the National Board examinations to have an even greater effect on the content of medical education programs than they do at present. The Council of Deans will explore the proposed changes during a program at the annual meeting.

In 1984, three years after the Association published a critical study of medical education in certain foreign-chartered schools, the Educational Commission for Foreign Medical Graduates instituted a more rigorous examination of foreign medical graduates seeking its certification. The new Foreign Medical Graduate Examination in the Medical Sciences is equivalent to Parts I and II of the National Board certification sequence. In its first two administrations, only four percent of U.S. citizen candidates passed the examination; alien FMGs passed at a twenty percent rate.

The revelation that medical schools in the Dominican Republic were the source of fraudulent medical degrees caused many state licensing boards to scrutinize the credentials of graduates of foreign medical schools more carefully. Some states have also imposed specific educational requirements on applicants for a medical license. Although directed toward denying inadequately educated graduates of foreign medical schools a license to practice, these requirements also apply to graduates of LCME-accredited schools and impose highly undesirable restrictions on the faculties of accredited institutions to determine educational policies and curricula. The Association expressed its concern about this trend to the officers of the Federation of State Medical Boards. At its 1985 annual meeting, the Federation adopted a resolution urging that legislative bodies not attempt to mandate specific details of the curricula of accredited medical schools in the United States and Canada. Instead these were viewed as the responsibility of the faculties and the accrediting body, to permit adaptation of medical student education to the rapidly changing practice of medicine. This action is consistent with an accord reached sixty years ago when the Federation and its members agreed to accept a medical school's membership in the Association as sufficient to ensure the quality of its educational program for medical students.

Building on the successes of the past three years, the Association has again helped to foster the Ad Hoc Group for Medical Research Funding, the coalition of more than 150 professional societies and voluntary health organizations that advocates enhanced appropriations for the NIH and ADAMHA. This arrangement has proved remarkably successful in convincing the Congress that the communities interested in biomedical and behavioral research can work together to assure continuation of the research productivity of these two agencies.

The Association was an active promoter for the recent consolidation of the Association for Biomedical Research and the National Society for Medical Research in the formation of a new organization, the National Association for Biomedical Research, to undertake

more vigorous efforts in the cause of continued availability of animal models for research, education, and testing. The AAMC's collaborative efforts with the American Medical Association and the American Physiological Society resulted recently in the establishment of an advisory council to NABR to greatly enlarge the number of professional societies, voluntary health organizations, and commercial companies now active in this cause.

This year the AAMC and the American Council on Education co-sponsored a forum within the ACE's National Identification Project for the advancement of women in higher education administration. The one and a half day program for twenty-five senior women faculty and ten male deans and presidents marked the first program of this nature in the Association's continuing efforts to advance the status of women in academic medicine.

The Association is regularly represented in the deliberations of the Joint Health Policy Committee of the Association of American Universities/American Council on Education/National Association of State Universities and Land-Grant Colleges, the Washington Higher Education Secretariat, and the Intersociety Council for Biology and Medicine.

The Association was one of five co-sponsors of an invitational conference on financing graduate medical education in an era of cost containment. The Council of Medical Specialty Societies was principal sponsor and organizer of the two-day meeting which brought together 200 participants to explore the effect of myriad changes in health care financing and delivery on graduate medical education.

The Association's Executive Committee meets periodically with its counterpart in the Association of Academic Health Centers. The staffs of the two organizations exchange information and collaborate on programs such as an ongoing study of university ownership of teaching hospitals.

Education

Whether or not the AAMC's General Professional Education of the Physician project can be considered the cause, the occasion, or the facilitator, it is clear that the AAMC membership both collectively and individually is giving a considerable degree of attention to the educational process.

Within the Association's governance structure, a joint working group of COD and CAS members prepared a commentary on the GPEP report to assist faculty and administrators using the document as an agenda of issues for the local review of educational policy and practice, and the OSR sponsored a series of discussions at national and regional meetings to identify the student's role and responsibility in improving the educational process.

The Group on Medical Education instituted a task force on the review of curricular innovations, and inaugurated a series of workshops for curriculum deans to assist in the introduction of educational change and in the management of the educational program. This group provides an ongoing forum for sharing information about curricular innovations, especially in the Innovations in Medical Education exhibits presented at each annual meeting.

The RIME Conference focuses the attention of researchers and evaluators on a single theme in its annual invited reviews. In the past two years these topics have related to important recommendations in the GPEP report. The 1984 theme was medical problem-solving and the 1985 topic was teacher training.

The Group on Student Affairs has been concerned about the residency selection process as it affects the orderly transition of the medical graduate to a residency program. The AAMC is concerned about the implications for the educational experience of medical students, and will be considering appropriate strategies for addressing this throughout next year.

The AAMC and the Department of Health and Human Services sponsored a Conference on the Clinical Education of Medical Students that was directly related to GPEP's focus on specific problems in clinical education. This conference and one for residents on the preceding day had as their goals reaching consensus on the most important problems and identifying ways that schools might resolve these threats to a quality clinical education. The conference combined commissioned papers published in advance and plenary presentations by acknowledged experts with extensive small group interactions. Conference proceedings will be published in 1986.

The GME plenary session organized for the 1985 meeting concentrated on evaluation in clinical education—specifically, the level of clinical competence possessed by graduates of M.D. programs, how those levels are currently monitored, and the lessons to be learned about clinical education and evaluation at each stage of the continuum.

The AAMC Clinical Evaluation Program continues to provide support to faculty responsible for clinical education and the 1985 annual meeting was the occasion for presentation of a series of materials for evaluation systems review and modification. Included among these are self-study instruments for use by institutions, departments, and training sites to review the system of evaluation and identify areas of specific strengths and weaknesses; a format for workshops designed to assist dean's office personnel and clerkship coordinators in the review of their evaluation policies and procedures; a manual providing the rationale for the assessments suggested and a brief description of the experience of schools used in the pilot study for the instruments; summary data from the pilot schools presenting a national perspective on systems problems, problem students, and evaluation content; and a critical analysis of the literature on the assessment of clinical competence.

Interest in methods to evaluate the skills involved in clinical competence and concerns expressed in the GPEP report about the emphasis in the Medical College Admission Test on the natural sciences, have led to the introduction of the MCAT essay pilot project. The 1985 spring and fall administrations included a forty-five minute essay question to develop the data

necessary to reach a decision about making the essay a regular component of the MCAT. The project evaluation plan calls for a two year trial to determine whether an essay provides unique and useful information for decisions on selecting students. The project is analyzing data from the essays written during 1985 to determine the performance characteristics of various examinee sub-groups and also the correlation of essay performance with other pre-admission variables. The project staff is also developing a study plan with a number of medical schools which will use essays in the selection of 1986 entering classes. Institutional case studies involving the use of the essay both with and without a centrally developed score are a part of the evaluation process. The results of the analyses conducted during the pilot project will be disseminated for review during the course of the project.

Other MCAT activities are underway as well. Staff is working with the schools participating in the MCAT interpretive studies program to identify valid measures of performance in the clinical years to serve as criteria for MCAT validity studies. Recent publications from the interpretive studies effort include a summary of the predictive validity data using performance in the first two years as a criterion, and the relationship between the MCAT science scores and undergraduate science GPA. A revised MCAT technical manual and an MCAT user's manual will be published in 1986. An *ad hoc* AAMC committee will examine a number of issues related to the MCAT program for a report to the Executive Council during the coming year.

The preliminary injunction obtained in January 1980 that protects the MCAT from the provisions of New York's test disclosure law remains in effect. A status call by the court scheduled for this past summer prompted a review of the entire matter by the Executive Council with the result that the Association will continue to pursue actively its legal action against the application of the law to the MCAT.

In March 1985 the Association sponsored a Symposium on Medical Informatics: Medical Education in the Information Age. Teams of academic leaders from fifty U.S. and Canadian medical schools met to consider the impact of advances in information science and computer and communications technologies on the clinical practice of medicine and educational activities of the academic medical center. This winter the conference proceedings will be published with the project steering committee's report on the state-of-the-art for medical informatics and its recommendations for medical center activities in this area. This project has been supported by the National Library of Medicine.

Biomedical and Behavioral Research

The Association continues its efforts to obtain adequate support for basic biomedical and clinical research and the training of investigators for academic posts. The areas of involvement are described in the section on National Policy in this report.

The Association has continued to spearhead efforts to enhance the scientific community's response to the increasingly vocal and effective animal rights organizations. The Association assisted in the formation of the National Association for Biomedical Research, which will monitor state and federal legislation, disseminate information about legislative/regulatory developments and develop positions and action strategies. Working in close cooperation with NABR is the Foundation for Biomedical Research, a non-profit organization designed to inform the American public about the proper and necessary role of animal models through films, print and television media, and an information clearinghouse.

A second Association initiative was the formation, in cooperation with the Association of American Universities, of an *ad hoc* committee to develop guidelines for institutional management of animal resources. The committee developed guidelines to assist universities and medical schools in a systematic review of policies and procedures related to the use of animals and suggested ways to improve the organization, management, and coordination of animal resources.

This spring, the Public Health Service issued its revised *Policy on Humane Care and Use of Laboratory Animals,* a revised *Guide for the Care and Use of Laboratory Animals,* and the *U.S. Government Principles for the Utilization and Care of Vertebrate Animals.* Despite these activities, several bills were introduced which would restrict access to and/or require greater accountability for the use of animals in research. The Association continues to support the position that full implementation of the PHS *Policy* and *Guide* are sufficient to insure a high standard of care yet facilitate scientific advancement.

Both the NIH and the Congress have conducted extensive policy discussions over the last 18 months on a variety of issues related to biomedical research. In response to the increasing pressures of grant competition, the NIH Director's Advisory Committee reviewed the extramural awards system. Discussion focused on two central issues. Does the current two-tiered system of review by scientific peer groups and institute advisory councils function effectively and efficiently? And are the grants themselves structured to produce the maximum benefit, both for the individual investigators and their research careers and for the biomedical research enterprise as a whole? Possible changes discussed included simplification of grant applications to decrease the workload for both applicants and review groups, and the use of longer award cycles for established investigators. The Committee also discussed longer periods of support for first-time applicants, weighing the benefits of longer grants against the danger of increases in the commitment base for the NIH budget.

NIH undertook further initiatives in 1985 to increase the number of physicians entering research careers. NRSA institutional training grant program guidelines for M.D.s were reissued. They recommended a minimum of two years of intensely supervised research training for the development of a competitive research career, with a breadth and depth of basic science knowledge as a foundation for future investigative work and no more than 20 percent of training time devoted to clinical activities. Finally, in order to qualify for renewal of research training grants, clinical departments should show that they have appointed at least as many M.D. postdoctorals as Ph.D.s, and follow the careers of former trainees for reasonable periods of time to document their continued research activity.

In 1985, the House of Representatives Committee on Science and Technology appointed a bipartisan Task Force on Science Policy. This task force, chaired by Representative Don Fuqua, is in the midst of a two-year in-depth review of the role of the federal government in the conduct and support of basic and applied

research and manpower and training. The task force has conducted hearings on a number of topics, including the goals of national science policy, the federal government's responsibility for the research infrastructure at universities, the role of scientists in the political process, and manpower and education. David R. Challoner, vice-president for health affairs at the University of Florida, represented the AAMC at the manpower hearings, stressing the importance of continued support for biomedical research training programs, especially for physician investigators.

As a result of the deliberations and initiatives by the NIH and the Congress, the AAMC appointed an *ad hoc* Committee on Research Policy in June 1985. The committee is chaired by Dr. Edward N. Brandt, former Assistant Secretary of Health and chancellor of the University of Maryland at Baltimore, and will review and formulate Association policy with regard to biomedical/biobehavioral research.

During this year, concern continued for the deteriorating state of research equipment and facilities in the nation's universities. Efforts to document and quantify these deficiencies were assisted by the Association. NIH has recently completed a study entitled "Academic Research Equipment Needs in the Biological and Medical Sciences," in which the medical and graduate school departments sampled indicated that their major needs were for instruments with costs of about $60,000 and for equipment maintenance. NIH is currently reviewing how the extramural grant review process currently handles equipment purchase and maintenance requests costing less than the $100,000 limit of the Shared Instrument Grant program of the Division of Research Resources. The major university associations recently completed an 18-month study of 23 facilities, "Financing and Managing University Research Equipment." This study makes recommendations to federal and state granting agencies and universities to streamline the acquisition, financing, use, and maintenance of university research equipment.

Modernization or new construction for research facilities also continues to be a pressing need. Much Association effort was devoted to the work of a federal Interagency Steering Committee on Academic Research Facilities, which devised a survey of Academic R&D Facilities in Science, Engineering, and Medicine. Unfortunately, OMB refused to allow this comprehensive study to proceed. The Association urged NIH to proceed with a pilot effort, and a thorough analysis of the existing physical plant and projected needs of nine universities, seven with medical schools, as well as nine independent hospitals and research institutes is underway. The pressure to obtain federal funds for research construction has built to the point where some universities have sought line item appropriations directly from Congress. This trend has been deplored by the AAMC and other higher education associations on the grounds that such facilities funding should be merit and need based. The Association continues to seek congressional support to reestablish the NIH competitively awarded facilities grants program, whose authority lapsed in 1968, and to this end the AAMC will closely examine a pending bill of the House Science and Technology Committee that would provide authority for a competitive matching grant program for science facilities through five federal agencies.

The questions of who should regulate biotechnology and to what extent continued to be a major concern. In an effort to delineate the federal role with respect to both research on and commercial application of biotechnology, the Cabinet Council Working Group on Biotechnology, through the White House Office of Science and Technology Policy, issued a "Proposal for a Coordinated Framework for the Regulation of Biotechnology" in December 1984. In addition to providing a concise index of U.S. laws related to biotechnology, the proposal attempted to clarify the policies of the major regulatory agencies involved in the review of research and products of biotechnology. The proposal recommended the establishment of a review mechanism, which would involve a two-tiered structure composed of five agency-based (NIH, FDA, EPA, USDA, and NSF) advisory committees, presumably modeled after the NIH Recombinant DNA Advisory Committee (RAC), under a coordinating parent board. Questions about the interactions of these committees with the parent board and the vagaries of the review process outlined by the EPA led the AAMC to join other members of the academic research community, including the NIH RAC, in commenting on this plan's potential to further confuse rather than clarify the review process for research proposals involving genetically engineered organisms.

The White House Office of Science and Technology Policy undertook a study of the major research universities under a panel of the White House Science Council. The report may contain policy proposals or other recommendations to strengthen the partnership of the research universities, industry, and the federal government and to address issues of support for research infrastructure and academic facilities. OSTP itself has been analyzing issues surrounding the indirect cost component of research funding. Motivated by the rising share of the total research budget which is committed to indirect costs, it is anticipated that they will seek a means of capping or controlling this portion of research costs. The AAMC has urged support for the principle of full federal payment of the legitimate costs of research conducted in universities.

Faculty

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

The Faculty Roster System, initiated in 1966, continues to be a valuable data base with information on current appointment, employment history, credentials and training, and demographic data for full-time salaried faculty at U.S. medical schools. In addition to supporting AAMC studies of faculty and research manpower, the system provides medical schools with faculty information for completing questionnaires for other organizations, for identifying alumni serving on faculties at other schools, and for producing special reports.

A survey of all full-time faculty in departments of medicine was conducted in cooperation with the Association of Professors of Medicine. Results of this study are being published in the *Annals of Internal Medicine*, and a comprehensive report is being prepared for the APM and the National Institutes of Health. A second survey of internal medicine faculty on research training is in progress. The combined data from these surveys and the Faculty Roster are a rich source of information on the extent of research activity for over 7,000 faculty members.

During 1985 the Faculty Roster data base is being matched to NIH records on research training and grant applications and awards to analyze the relationship between training and academic careers and the faculty's role in the conduct of biomedical research. These activities, as well as the maintenance of the Faculty Roster data base, receive support from the National Institutes of Health.

Work is in progress for the report produced periodically on the *Participation of Women and Minorities on U.S. Medical School Faculties*. The publication will report, for the first time, faculty rank and tenure status by department.

Based on the Faculty Roster, the Association maintains an index of women and minority faculty to assist medical schools and federal agencies in affirmative action recruitment efforts. Since 1980 more than 1100 recruitment requests from medical schools have been answered by providing records of faculty members meeting the requirements set by search committees. Faculty records utilized in this service are those for individuals who have consented to the release of information for this purpose.

As of June 1985, the Faculty Roster contained information on 52,438 full-time salaried faculty and 2,515 part-time faculty. The system also contains 58,405 records for persons who previously held a faculty appointment.

The Association's *1984–85 Report on Medical School Faculty Salaries* summarizes compensation data provided by 122 U.S. medical schools. The tables present compensation averages and percentile statistics by department and rank for basic and clinical science faculty. Salary data are also displayed according to school ownership, degree held, and geographic region for the 35,307 full-time faculty reported to the survey.

Students

As of September 9, 1985, 32,728 applicants had filed 306,221 applications for the entering class of 1985 in the 127 U.S. medical schools. These totals, although not final, represent a decrease in the national applicant pool compared to the final figures for the 1984 entering class. The 1985 applicant pool is estimated to be 32,800 applicants, which would represent an 8.7 percent decrease from 1984–85.

The total number of new entrants to the first year medical school class decreased from 16,480 in 1983 to 16,395 in 1984. Total medical school enrollment also decreased from 67,327 to 67,016.

The number of women new entrants reached 5,469, 1.8 percent higher than 1983; the total number of women enrolled was 21,316, a 3.2 percent increase. Women held 31 percent of the places in the nation's medical schools in 1984 compared to 25 percent for the 1979–80 entering class.

There were 1,440 underrepresented minority new entrants, 8.8 percent of the 1984 first year new entrants. The total number of underrepresented minorities was 5,707 or 8.5 percent of all medical students enrolled in 1984.

For the 1985–86 first-year class, 927 applicants were accepted under the Early Decision Program by the 75 medical schools offering such an option. Since each of these applicants filed only one application rather than the average 9.4 applications, the processing of approximately 7800 additional applications and scores of joint acceptances was avoided. In addition, the program allowed successful early decision applicants to finish their baccalaureate programs free from concern about admission to medical school.

One hundred and one medical schools participated in the American Medical College Application Service to process first-year application materials for their 1985 entering classes. In addition to collecting and coordinating admission data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admission, matriculation and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Steering Committee of the Group on Student Affairs.

The AAMC Advisor Information Service circulates rosters and summaries of applicant and acceptance data to subscribing health professions advisors at undergraduate colleges and universities. In 1984, 333 advisors subscribed to this service.

The AAMC continues to investigate the application materials of prospective medical students that contain suspected admission irregularities. These investigations, directed by the "AAMC Policies and Procedures for the Treatment of Irregularities in the Admission Process," help to ensure the provision of complete, accurate information to medical school admissions officers and the maintenance of high ethical standards in the medical school admission process.

Although the number of Medical College Admission Test examinees has not always been a good indicator of the size of the applicant pool, several recent changes in the MCAT population are of interest. In 1984, the number of examinees decreased eight percent and represented the largest single year decrease in the past seven years. This appears to correspond with the projected nine percent drop in the number of applicants for the 1985 entering class. The decrease in the number of individuals sitting for the MCAT continued into the spring 1985 administration. Compared to the spring 1984 examinee group, seven percent fewer individuals sat for the spring 1985 MCAT administration.

The Medical Sciences Knowledge Profile examination was administered for the sixth time in June 1985 to 1,823 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC in evaluating individuals seeking placement with advanced standing. While 3.8 percent of those taking the test had degrees in other health professions, 91 percent of all registrants were enrolled in foreign medical schools.

Beginning in 1983, a joint effort was initiated to link data from the National Resident Matching Program to the enrolled student file of the AAMC. Listings were

then forwarded to the medical schools for corrections and updates to residency assignments for all seniors, prior year graduates, and Fifth Pathway students registering for the 1983 match. This effort continued in 1984 and 1985. By reporting the results of this data collection effort to hospitals, and by incorporating deletions and additions provided by the hospitals, the AAMC is now able to track the progress of medical school graduates, (beginning with 1983) through their graduate medical education. This effort represents another step in the development of a resource for longitudinal studies in medical education and medical manpower.

The Association is actively involved in monitoring the availability of financial assistance and working to insure adequate funding of the federal financial aid programs used by medical students. As federal financial aid programs shrink and medical school costs rise, concern about the availability and adequacy of financial aid and increasing levels of student indebtedness grows. This concern resulted in a recently completed study of medical student financing carried out with the support of the Department of Health and Human Services. The Association also worked closely this year with the schools and with DHHS to monitor and reduce delinquency rates in the Health Professions Student Loan program. The AAMC is represented on a recently appointed task force which will work with DHHS staff in review of the regulations covering the write-off of delinquent and defaulted loans.

The AAMC also produced a guide for medical schools designed to assist them in reaching compliance with federal regulations on satisfactory academic progress and receipt of title IV student aid.

Through its Office of Minority Affairs, the AAMC is administering several projects to enhance opportunities for minorities in medical education. Several Health Career Opportunity Program grants were received. The first grant provided two types of workshops to reinforce and develop effective programs for the recruitment and retention of students underrepresented in medicine. Of these, the Simulated Minority Admissions Exercise Workshop is for medical school personnel concerned with the admission and retention of minority students. The Training and Development Workshops for Counselors and Advisors of Minority Students provide information about ethnic and racial minority students and train counselors and advisors to work with the latest techniques appropriate for underrepresented minority students. An important objective is to have participants gain information about the differences among minority groups and to help participants develop alternative techniques for each group.

Phase one has been completed in a second grant to develop a tracking mechanism for students participating in Health Career Opportunity retention programs.

With Robert Wood Johnson Foundation support the Office of Minority Affairs developed *Minority Students in Medical Education: Facts and Figures II.* Other work has been carried out with the Macy Foundation to determine the extent of minority medical student participation in special enrichment or preparatory programs.

The *1986–87 Minority Student Opportunities in U.S. Medical Schools* questionnaire was distributed to U.S. medical schools. This biennial publication describes minority student programs and recruitment activities of each medical school.

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

Institutional Development

The AAMC Management Education Programs, now in their fourteenth year, offer seminars to enhance the leadership and management capabilities of AAMC member institutions. These programs for senior academic medical center officials emphasize management theory and techniques. The Executive Development Seminar, an intensive week-long session, was offered twice during the last year. Fifty-one medical school department chairmen and assistant and associate deans from thirty-eight institutions participated in the first program; the second was offered for new deans. These seminars assist institutions in integrating organizational and individual objectives, strengthening the decision-making and problem-solving capabilities of academic medical center administrators, developing strategies for more flexible adaptation to changing environments, and developing a better understanding of the function and structure of the academic medical center. Due to the high demand for this seminar, it will be offered twice during the 1985–1986 year.

In addition to the Executive Development Seminars, special topic workshops are offered. A seminar on Information Management in the Academic Medical Center was attended by sixty-one individuals from twenty-eight institutions, and will be presented again in the 1985–1986 year. The seminar acquaints administrators with the problems and opportunities arising from the rapid development of advanced information technologies and assists them in meeting the challenges of information management in the complex environment of the academic medical center. For the fifth year, a seminar focusing on the academic medical center/VA medical center affiliation relationship was conducted for VA medical center associate directors as part of their professional development program. This program was co-sponsored by the Veterans Administration.

A series of educational seminars devoted to the challenges posed to academic medical centers by alternative medical care delivery systems is under development. The seminars will be held regionally during the fall and winter of 1985 and will include an analysis of the current environment, a conceptual framework for analyzing the academic medical centers' position and role in this environment, and an exploration of the experience of several institutions in coping with alternative delivery systems such as brokered care or capitated systems. In addition, plans are underway for a program to address the process and technological innovation and planning for the acquisition and management of high technology resources for research and patient care.

A survey to identify the most salient problems and issues facing medical school faculty clinical practice was sent to vice presidents, deans, hospital directors, department chairmen and faculty representatives. The results highlighted the need for greater coordination of practice activity in the academic medical center in order to practice high quality, cost effective medicine in the changing environment while preserving academic values.

An outcome of this survey project was the appointment of an *ad hoc* committee charged with discussing the issues raised and suggesting AAMC projects or programs that would be of service to member institutions in dealing with the changes in the practice environment. The committee's initial meeting was held in September 1985; a report is due in spring 1986.

Teaching Hospitals

The future financing of graduate medical education and prospective payment for hospitals have been overriding concerns of the AAMC throughout the year. The Association reviewed several legislative proposals to change current financing policy for residency training. The Association commented on several significant proposals in the FY 1986 budget to amend Medicare's Prospective Payment System for inpatient hospital care and also addressed published regulations for the third year of PPS. The proposals to amend the payment system fall inequitably upon the nation's teaching hospitals.

The AAMC Committee on Financing Graduate Medical Education first met in September 1984 to consider methods of financing residency training in the future. The committee and the AAMC Administrative Boards and Executive Council held a special session for reports on GME financing studies being conducted by the federal government and the Commonwealth Fund Task Force on Academic Medical Centers. An intentionally provocative financing proposal was presented by Robert Petersdorf, dean, University of California, San Diego School of Medicine to stimulate discussion. After wide-ranging discussion on options to modify current GME funding practices, the committee reassessed the AAMC's traditional position supporting financing for all approved residency positions through hospital patient care revenue and concluded this approach was at risk as third-party payers changed their hospital payment policies. In its exploration of alternative approaches to financing GME, the committee concentrated its efforts on a series of major questions relating to whether payments should continue to come through patient care revenues or be separately identified, the number of years of training to be financed, whether the financing method should be used to influence the mix of specialists being trained, the appropriate roles for the federal and the state governments and voluntary organizations in decisions regarding the numbers and types of physicians to be trained, supporting training in non-hospital sites, and funding for foreign medical graduates. Because of the wide range of views held by members, the committee's chairman discussed the deliberations with AAMC Administrative Boards to elicit further direction and comments. The debate resulted in publication of a "Statement of Issues," describing the competing views on policy options under consideration by the Committee. This was sent to all AAMC constituents for discussion at each council's spring meeting. Constituents were surveyed about the GME financing problems facing teaching hospitals in a price competitive market, whether training for foreign medical graduates should be supported, and the length of training which should be supported. Results showed a consensus that third party payers should continue to support graduate medical education through first board certification. It is expected that the committee's final report will be issued in the coming year.

The Subcommittee on Health of the Senate Finance Committee initiated congressional debate with a hearing on current and future financing for residency training. The AAMC testimony described Medicare's historical support through payment of the direct medical education passthrough and the resident-to-bed adjustment to prospective payments. The Association emphasized the need to maintain and strengthen the medical education system including residency training in the face of dramatic changes in the environment for teaching hospitals. These institutions are finding it increasingly difficult to accommodate their multiple services of education, research and patient care, and their financial stability is at immediate risk. The Association fears that in a price competitive market, tertiary care teaching hospitals will suffer financially because paying an average price per case is insufficient for teaching hospitals. Even a subsidy for graduate medical education is insufficient if it does not include additional expenses for tertiary care services, stand-by, new technology, and charity care.

Senator David Durenberger, chairman of the Senate Finance Health Subcommittee, and Senators Robert Dole and Lloyd Bentsen introduced S. 1158 which would freeze Medicare payments for GME in FY

1986. Subsequently, the proposal would change the conditions for Medicare support for graduate medical education, financing only the training of LCME-approved medical school graduates and foreign medical graduates who are U.S. or Canadian citizens. Financial support would be limited to the lesser of five years of residency or initial board eligibility. These economic disincentives are intended to reduce the number of subspecialty and lengthy specialty training positions available. The Association's testimony emphasized the real costs of graduate medical education and the interwoven relationship of residency training and patient services in teaching hospitals. The Association suggested that the bill be amended to increase the direct education passthrough by the same rate used to increase federal component of DRG prices, that residency training be supported at least through initial board eligibility, that the proposal allow billing for professional services for residents beyond initial board eligibility, and that Medicare support be eliminated for all foreign medical graduates over a three-year period.

An amended S. 1158 would appear to meet many AAMC concerns and recommendations. However, several other legislative proposals are currently on the table. Senator Dan Quayle has proposed establishing a registry of teaching hospitals as part of a system to ensure a prescribed number of residency positions in primary care specialties. Although a residency would be available for every graduate of an LCME-approved medical school, there would be no guarantee that it be in the specialty of the graduate's choice. The proposal would require that an affiliation agreement between a teaching hospital and medical school be in place to allocate primary care training positions. Finally, at least 75 percent of the residents in a program would have to be graduates of an LCME or AOA approved school. A National Council on GME would determine the appropriate number of primary care residency positions.

The AAMC testified on this proposal before the Senate Committee on Labor and Human Resources' Subcommittee on Employment and Productivity. In regard to the requirements of an affiliation agreement, the Association testified that such agreements are established primarily for securing clinical resources for the education and training of medical students, and are highly varied. The Quayle bill would require regulations to define the nature and content of acceptable affiliation agreements, and the Association opposes federal intrusion into this area. Secondly, the AAMC stated that the graduate medical education system needs flexibility to permit graduates to prepare themselves for careers in those specialties for which they are best suited by their temperament, skills, and interests. Finally the U.S. must consider the desirability of training individuals from other countries to improve the quality of their nation's health care, regardless of how such training is funded.

A compromise proposal forged in the Committee on Labor and Human Resources eliminated a clause that would have prohibited federal GME financial assistance for hospitals not complying with the primary care percentage or the FMG limit. The medical school affiliation requirement was removed and it was agreed that residents in obstetrics-gynecology would not be counted as primary care residents. The National Advisory Council could recommend different minimum percentages for classes for hospitals rather than a single national percentage target. The committee unanimously reported the revised bill for Senate consideration, and agreed to allow Senator Kennedy to offer a committee amendment when the bill comes up for debate. That amendment would add financial incentives for hospitals meeting the nationally-set primary care targets. Payments to other hospitals would be reduced to assure budget neutrality.

The AAMC testified before the Subcommittee on Health and the Environment of the House Energy and Commerce Committee in an educational briefing on the federal government's role in funding graduate medical education. The AAMC's testimony pointed out that while the majority of residents are concentrated in a small number of hospitals, specialties, and states, the remaining residents are widely distributed, and public policy makers must carefully consider the varying impact of proposed policies. The AAMC stated that since its inception Medicare had paid its share of the added expenses hospitals incurred when providing clinical training for residents, nurses, and allied health personnel. The Association cautioned that the current emphasis on reviewing national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated.

Congressman Henry Waxman, chairman of the Subcommittee on Health and the Environment, has introduced a bill to alter the method by which Medicare and Medicaid pay for graduate medical education by limiting the amount paid per resident. It would influence physician specialty mix by weighting the count of residents to favor primary care positions. Also the "indirect medical education adjustment" would drop to nine percent in FY 1986, with further decreases in subsequent years if regulations are developed for hospitals with a disproportionate share of low income and Medicare patients. The HHS Secretary is permitted to develop a sliding scale for resident-to-bed ratios in excess of .1.

A fourth legislative proposal to limit Medicare's funding of graduate medical education was introduced

by Congressmen Ralph Regula and Thomas Tauke. It would establish a separate formula-driven grant mechanism for Medicare's share of GME expenses. The allocation formula compares the ratio of Medicare's portion of full-time equivalent (FTE) residents in each hospital to Medicare's portion of total FTE residents nationally. The allocation can be adjusted for area differences in stipends, specialty mix, and service area. New entrants into the medical education field would be allowed to claim their actual number of residents in the initial year, but hospitals could not increase their number of residents by more than ten percent in any one year without penalty.

The financing of graduate medical education was also addressed outside the legislative arena, in proposed regulations published by the Health Care Financing Administration to freeze permanently payments to hospitals for direct medical education. The proposed freeze, effective July 1, 1985, would be based on a cost reporting year beginning on or after October 1, 1983 but before October 1, 1984. The AAMC vigorously opposed these regulations in comment letters to HCFA, HHS, and White House officials and to members of Congress. The Association believes a policy change of this magnitude is highly inappropriate prior to resolution of the on-going congressional debate on the proper role for Medicare. Moreover, the AAMC believes Medicare has a responsibility to help train professionals who serve its present and future beneficiaries. The Association asked HCFA to suspend further action on a regulatory freeze in the direct medical education passthrough until Congress has considered fully and acted upon a Medicare policy for supporting hospital costs for medical education activities; the AAMC was joined in its effort by twenty-nine other health organizations. The AAMC also asked Congress to stop this regulation until appropriate congressional review had occurred. Finally, to evaluate the legality of HHS' implementation of these proposed regulations, the AAMC requested counsel to investigate the avenues available for challenging implementation of these proposed regulations. Legal action may not be necessary if Congress endorses a recommendation from the Subcommittee on Health of the House Ways and Means Committee to prohibit HHS from imposing a freeze on direct medical education payments. Nevertheless, final rules to implement this freeze were published by HCFA on July 5, 1985.

The administration's proposed FY 1986 budget included reductions in health care expenditures beyond the freeze in the direct medical education payments to hospitals. The budget proposed reductions of $4.2 billion in 1986, with seventy-nine percent of the Medicare savings coming from changes affecting providers of health care. Individually, each proposal would result in a substantial reduction in Medicare revenues for teaching hospitals; collectively, the proposals would result in an unparalleled reduction in Medicare revenues, seriously weakening the financial stability of many of the nation's teaching hospitals. In particular, the budget called for a fifty percent reduction in the indirect medical education adjustment, a freeze in the diagnosis-related group (DRG) per case payment to hospitals for Medicare inpatients, and a freeze in Medicare payments to physicians as well as the freeze in the direct medical education payment.

The Medicare Adjustment for the Indirect Cost of Medical Education: Historical Development and Current Status, a paper by Judith R. Lave commissioned by the AAMC, was invaluable as the Association confronted these severe budgetary measures. The publication describes this adjustment's original purpose to recognize the additional costs incurred by providing tertiary care and other unique services in the teaching hospital setting. The paper points out that the adjustment is necessary due to the limitations of the DRG as a unit of payment and recommends modifying the statistical methodology used to calculate the percentage increase.

The Association addressed specific budget proposals in a February 1985 policy position paper. The AAMC vigorously opposed any freeze in diagnosis-related group prices; strongly recommended that Congress either amend the prospective payment system so that payments would be based on a DRG-specific, blended rate of hospital-specific and federal component prices, or amend the DRG price formula so it is based on a blend of fifty percent hospital-specific and fifty percent regional average costs; supported recomputing the resident-to-bed adjustment using current and corrected data; strongly opposed any change or reduction in the passthrough for direct medical education costs at present; supported correcting the wage index numbers used in prospective payments but recommended amending the law to eliminate the current requirement that the new index numbers be applied retroactively to October 1, 1984; and recommended Congress require HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment. The position paper concluded that for the Medicare prospective payment system to provide hospitals with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data corrected, and real differences in the costs of various types of hospitals recognized.

The Association's testimony before the Subcommittee on Health of the House Committee on Ways and Means reiterated that the FY 1986 budget pro-

posals would require major changes in the Medicare system for inpatient care, and focused specifically on the DRG price freeze, the fifty percent reduction in the indirect medical education adjustment, and the freeze in direct medical education costs.

The Association also testified before that subcommittee regarding the technical issues underlying the current policy debate on Medicare's prospective payment system. Six concerns were highlighted in the testimony: the limited number of factors used to account for differences in hospital costs; the relationship between prospective payment prices and the phase-in schedule; the computation and role of the resident-to-bed adjustment in a system which uses hospital-weighted prices but lacks a measure of patient severity; the method of determining Medicare's share of direct medical education expenses; a suggestion for assisting disproportional share providers; and the legislated retroactivity of the wage index adjustment. In particular, the Association reiterated its opposition to the proposed budgetary cuts and called for the HHS to recompute the resident-to-bed adjustment.

The subcommittee reported recommendations regarding changes in the Medicare program in July. The Association supported its recommended one percent increase in DRG payments rather than a freeze, the development of a disproportional share adjustment, a recalculated indirect education adjustment of 8.1 percent (8.7 percent without a disproportional share adjustment), no freeze on direct medical education costs, and a one year pause in the transition towards a national payment rate by DRGs for hospitals. The Association opposed the one year extension of the physician fee freeze.

While Congress was considering the budget proposals, HCFA published regulations on the third year of prospective payment, requiring numerous and extensive changes. In brief, the proposed rules would freeze DRG prices and revise their weights, recalculate the thresholds for length of stay outliers, modify the wage index adjustment, and change the methodology used to count residents. The proposed change in resident counting would have all hospitals count residents on September 1, excluding those assigned to outpatient settings.

In comments to HCFA on the proposed regulations, the Association opposed the proposed DRG price freeze; supported the use of the "gross" index of hospital wages to determine hospital payments, but opposed its retroactive implementation; requested that HCFA alternate the use of charge and cost-based reweighting of the DRG weights; supported the specific reclassification of DRGs as contained in the proposal, but opposed reclassification without following normal rulemaking procedures; and supported the elimination of mandatory medical review of outliers and payment for such case when the bill is presented. In addition, the AAMC strongly opposed the removal of residents assigned to the hospital outpatient department from the resident count. The House Ways and Means Committee added clear language to prohibit HCFA from excluding residents assigned to outpatient units, and the AAMC hopes to obtain similar language from the Senate Finance Committee. Since the issue may remain unclear for some time, the AAMC has urged all members to maintain their resident count data in order to recreate an accurate report of residents assigned to outpatient units upon resolution of this issue.

When Medicare enacted its prospective payment system for inpatient hospital costs, Congress directed HHS to develop a recommended policy on Medicare's payment of capital costs by October 1986. An Association policy position was developed under the guidance of an *ad hoc* Committee on Capital Payments for Hospitals. It supports a percentage add-on to the prospective payment for capital payments for movable equipment, to include plant and fixed equipment only after an acceptable transition period.

The AAMC wrote to HHS to express grave concerns with the proposed regulations implementing the "Baby Doe" amendment to the Child Abuse Prevention and Treatment Act, which identified the withholding of medically indicated treatment as a form of child abuse that must be reported to state child protection services. It defined withholding of medically indicated treatment as the failure to respond to life threatening conditions except when the infant is irreversibly comatose, treatment would merely prolong dying, or the treatment would be virtually futile and, therefore, inhumane. The AAMC had objected to the legislation because it inadequately addressed the complexities of the issues and decisions involved, and the proposed regulations gave even less recognition to these complexities. Through a series of "clarifying definitions" the proposed regulations sought to force aggressive treatment for each infant. This approach failed to recognize that truly difficult decisions must be made when medical care can reverse only certain aspects of the infant's condition, but cannot correct or reverse the underlying disease or permanent brain damage.

The AAMC objected to the implication in the regulations that such children must be aggressively treated when standard medical practice would be "a limitation of all medical means for prolongation of life." The Association reminded HHS that aggressive treatment of all severely ill infants would tax available neonatal care resources, perhaps precluding other infants, who would clearly benefit, from receiving intensive neonatal care. Finally, the AAMC recommended that the "clarifying definitions" developed by HHS be

removed from the proposed regulations and that the law's definition of "withholding medically indicated treatment" not be changed.

In related developments, the Civil Rights Commission held a hearing to examine the need to apply Section 504 of the Rehabilitation Act to this type of case. Notwithstanding the recent passage of the amendments to the Child Abuse Act, the Civil Rights Commission intends to recommend that Congress amend the legislation that prohibits discrimination against the handicapped to specifically address congenitally impaired infants. Secondly, the Supreme Court heard the case of the *American Hospital Association v. Heckler*, in which the Second Circuit Court of Appeals questioned the applicability of Section 504, and which formed the basis for striking down the original Baby Doe regulations.

The AAMC testified on uncompensated care and the teaching hospital before the Subcommittee on Health of the Senate Finance Committee and the National Council on Health Planning and Development late in 1984. The Association described the increasingly competitive marketplace for hospital services as forcing hospitals to balance the costs of uncompensated care for current patients with the hospital's fiduciary responsibility to remain viable to serve future patients. The AAMC noted that teaching hospitals have historically fulfilled special missions as a consequence of their location in metropolitan areas, frequently in inner city neighborhoods. In response to the hospital's location and the area's shortage of health personnel, teaching hospitals have often established large clinics and primary care services to meet neighborhood needs, even at a financial loss. The teaching hospital's area-wide programs for burn, trauma, high risk maternity, alcohol and drug abuse, and intensive psychiatric care may also attract patients unable to pay for their care. As a result, many public and private teaching hospitals are major providers of uncompensated care. The Association emphasized that uncompensated care is a problem in a competitive environment because such care is unevenly distributed across hospitals, handicapping those serving the indigent and medically indigent.

Final rules on disclosure responsibilities and sanction criteria to be used by Peer Review Organizations were issued by HHS. These regulations allow PROs to disclose hospital-specific information on quality and appropriateness of health care services subject to certain new requirements. PROs must notify hospitals if they intend to release information, provide hospitals with a copy of the information, and allow the hospital to comment, with those comments forwarded to the requestor. Aggregate data that does not identify institutions, individual patients, or practitioners can be disclosed without comment, but release of patient-specific information requires the consent of the patient. This emphasis on PRO disclosure responsibilities reiterates HHS's intention to allow public access to data that the AAMC believes could be misused or misinterpreted, such as hospital death rates and prevalence of hospital-acquired infections. The language allowing hospitals' comments to become part of the requested information will be especially important as these data are released and interpreted in the public arena. Because of the public interest in this information and the sophistication needed to properly understand it, analyses may oversimplify findings. The AAMC urged its members to establish a carefully defined internal process that provides timely responses during the comment period provided.

Communications

News media, both regional and national, view the AAMC as a major source of news concerning medical education, medical research policy and funding, and patient care issues. Each week more than 25 news reporters who are developing stories contact the Association for its expertise and opinions. In addition the Association generates stories through news releases, news conferences, and personal interviews.

The Association's major publication continues to be the *AAMC's President's Weekly Activities Report*, which is circulated to more than 6,000 individuals 43 times a year. Each publication reports on AAMC activities and federal actions having a direct effect on medical education, biomedical research, and patient care.

The *Journal of Medical Education* published 977 pages of editorial material in the regular monthly issues, compared with 1,015 pages the previous year. The published material included a total of 78 regular articles, 72 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. The monthly circulation averaged 6,100.

The volume of manuscripts submitted to the *Journal* for consideration continued to run high. Papers received in 1984–85 totaled 403, of which 137 were accepted for publication, 205 were rejected, 24 were withdrawn, and 37 were pending as the year ended.

In addition to the regular monthly issues, a 216-page Part 2 to the *Journal* was published on the report of the Project Panel on the General Professional Education of the Physician and College Preparation for Medicine. The publication was titled *Physicians for the Twenty-First Century.*

About 24,000 copies of the annual *Medical School Admission Requirements*, 5,000 copies of the *AAMC Directory of American Medical Education*, and 4,000 copies of the *AAMC Curriculum Directory* were sold or distributed. The AAMC also produced and distributed numerous other publications, such as directories, reports, papers, studies, and proceedings. Newsletters include the *COTH Report*, which has a monthly circulation of about 2,800; the *OSR Report*, which is circulated twice a year to medical students; and *STAR*, which is printed four times a year and has a circulation of 1,000 student affairs personnel.

Information Systems

The Association's computer system consists of a Hewlett-Packard 3000, Series 68 and a Hewlett-Packard 3000, Series 48, each with a high speed laser printer. The use of over one hundred terminals and enhanced data communication technology has provided improved response time and permits the Association to meet the needs of its membership and staff. Database development continues as a top priority to minimize data redundancy and to provide responsive on-line information retrieval. More sophisticated computer-generated graphic art now permits the creation of 35mm slides and the preparation of other camera art, reducing outside graphic art costs.

The American Medical College Application Service system provides the core of the information on medical students by collecting biographic and academic data, and linking these data to MCAT scores. A sophisticated software system provides participating medical schools with timely and reliable statistics with national comparisons. The system generates data files for schools and applicant pool analyses and provides the basis for entering matriculants in the student record system.

AMCAS is supplemented by the Medical College Admission Test reference system of score information, a college information system on U.S. and Canadian schools, and the Medical Science Knowledge Profile system on individuals taking the MSKP exam for advanced standing admission to U.S. medical schools.

A student record system, maintained in cooperation with the medical schools, traces the progress of individual students from matriculation through graduation. Supplemental surveys such as the graduation questionnaire and the financial aid survey augment the student record system.

After each match, the National Resident Matching Program obtains information on unmatched participants and eligible students who did not enroll. The Association, using an initial data file supplied by NRMP, produces match results listings for each medical school, updates the NRMP information using current student records system data and listings returned from the medical schools, prepares hospital assignment lists for each medical school, and generates a final data file for use in NRMP's tracking study.

The Student and Applicant Information Management System consolidates into one comprehensive database more than a decade's information on applicants, medical students, and residents. SAIMS provides data for a wide variety of reports including cross-sectional and longitudinal studies performed by Association staff for researchers at member institutions and for others.

Through the cooperation of U.S. medical school staffs, the Association updates the Faculty Roster System's information on salaried faculty and periodically provides schools with an organized, systematic profile of their faculty. A survey of medical school faculty salaries is published annually and is available on a confidential, aggregated basis in response to special queries.

The Association maintains an on-line repository of information on medical schools of which the Institutional Profile System is a major component since it contains data concerning medical schools from the 1960s to the present. It is constructed both from survey results sent directly from the medical schools and from other information systems. The information reported on Part I of the Liaison Committee on Medical Education annual questionnaire complements the Institutional Profile System and is used to produce the report of medical school finances published annually in of the *Journal of the American Medical Association.*

The Association also collects and maintains information on teaching hospitals. The comprehensive *Directory of Educational Programs and Services* and surveys on executive salaries, housestaff stipends and benefits, and academic medical center financing are published annually.

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

Treasurer's Report

The Association's Audit Committee met on September 3, 1985, and reviewed in detail the audited statements and the audit report for the fiscal year ended June 30, 1985. Meeting with the committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 12, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $12,547,089. Of that amount, $11,962,157 (95.3%) originated from general fund sources; $36,031 (0.3%) from foundation grants; $548,901 (4.4%) from federal government grants and contracts.

Expenses for the year totaled $11,358,696 of which $10,627,762 (93.6%) was chargeable to the continuing activities of the Association; $182,033 (1.6%) to foundation grants; $548,901 (4.8%) to federal government grants and contracts. Investment in fixed assets (net of depreciation) decreased by $135,625 as a result of the sale of outdated computer equipment. Balances in funds restricted by grantors decreased $141,025 to $338,186. After making provisions for Executive Council designated reserves for special programs in the amount of $430,000, unrestricted funds available for general purposes increased $1,274,758 to $10,981,399, an amount equal to 96% of the expense recorded for the year. This reserve accumulation is within the directive of the Executive Council that the Association maintain as a goal an unrestricted reserve of 100% of the Association's total annual budget. It is of continuing importance that an adequate reserve be maintained.

The Association's financial position is strong, but with the multitude of complex issues facing medical education, it is apparent that the demands on the Association's resources will continue.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
BALANCE SHEET
June 30, 1985

ASSETS

Cash		332,197
Investments		17,566,132
Accounts Receivable		609,550
Deposits and Prepaid Items		52,633
Equipment (Net of Depreciation)		1,198,641
TOTAL ASSETS		19,759,153

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		1,187,281
Deferred Income		1,625,172
Fund Balances		
Funds Restricted by Grantor for Special Purposes		338,186
General Funds		
Funds Restricted for Plant Investment	$ 496,856	
Funds Restricted by Executive Council for Special Purposes	3,931,618	
Investment in Fixed Assets	1,198,641	
General Purposes Fund	10,981,399	16,608,514
TOTAL LIABILITIES AND FUND BALANCES		$19,759,153

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
OPERATING STATEMENT
Fiscal Year Ended June 30, 1985

SOURCE OF FUNDS

Income	
Dues and Service Fees from Members	3,259,881
Private Grants	36,031
Cost Reimbursement Contracts	548,901
Special Services	5,399,867
Journal of Medical Education	103,113
Other Publications	477,953
Sundry (Interest $1,892,803)	2,721,343
TOTAL SOURCE OF FUNDS	$12,547,089

USE OF FUNDS

Operating Expenses	
Salaries and Wages	4,629,553
Staff Benefits	871,312
Supplies and Services	3,790,135
Provision for Depreciation	348,513
Travel and Meetings	1,119,566
Subcontracts	544,248
Net Loss on Disposal of Fixed Assets	55,369
TOTAL EXPENSES	11,358,696
Decrease in Investment in Fixed Assets (Net of Depreciation)	(135,625)
Transfer to Executive Council Reserved Funds for Special Programs	210,994
Reserve for Replacement of Equipment	(20,709)
Increase in Restricted Fund Balances (Decrease)	(141,025)
Increase in General Purposes Funds	1,274,758
TOTAL USE OF FUNDS	$12,547,089

AAMC Membership

	1983–84	1984–85
Institutional	126	127
Provisional Institutional	2	1
Affiliate	16	16
Graduate Affiliate	1	1
Subscriber	16	13
Academic Societies	76	79
Teaching Hospitals	434	435
Corresponding	47	35
Individual	1099	1074
Distinguished Service	65	68
Emeritus	60	60
Contributing	5	5
Sustaining	10	10

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