Association of American Medical Colleges

1985-86 ANNUAL REPORT

Photograph: The Johns Hopkins University School of Medicine

1985-86 Annual Report

Contents

President's Message 2
The Councils 6
National Policy 15
Working with Other Organizations 23
Education 25
Biomedical and Behavioral Research 27
Faculty 30
Students 31
Institutional Development 33
Teaching Hospitals 34
Communications 40
Information Systems 41
Treasurer's Report 42
AAMC Membership 44
AAMC Committes 45
AAMC Staff 49

Association of American Medical Colleges
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President's Message

The past year has been an important one for the Association of American Medical Colleges as we have seen the retirement of John A. D. Cooper from the AAMC presidency. As the Association's first full-time president, he had shaped its programs and directed its actions for seventeen years. It is to his great credit that the organization whose leadership I have undertaken is so strong and vital. Principal among the Association's assets are the intrinsic value of our mission to support academic medical centers and the tradition of using the Association as a forum for building consensus among the diverse components of our constituency. Complementing these are the active and involved constituency and the dedicated and talented staff who serve them. These strengths will be important anchors as we begin an internal evaluation of our organization and its priorities for the future.

As I look over the important events of the last year, several themes emerge that will continue to occupy our attention in the coming year. Like all elements of our society, academic medical centers will feel the impact of the congressional priorities of budget reduction and tax reform. While uncertainty may exist about how the reductions in budget deficits mandated by Gramm-Rudman-Hollings will be achieved, it does appear that Congress is now willing to accept program reductions in areas where support had once been assured. It is regrettable that in its concern to achieve budget targets Congress seems willing to accept indiscriminate cuts without regard to merit or the promise of future benefit integral to education and biomedical and behavioral research. We hope that Congress will be attentive to the Report of the White House Science Council Panel on the Health of U.S. Colleges and Universities which states, "One conclusion is clear: our universities today simply cannot respond to society's expectations for them or discharge their national responsibilities in research and education without substantially increased support."

Other legislative actions herald congressional interest in the activities of academic medical centers and presage increasing pressures for change in important aspects of our operations. By large margins both the House of Representatives and the Senate overrode President Reagan's veto of legislation reauthorizing certain programs of the National Institutes of Health, despite scientists' concern that the bill provided unprecedented congressional involvement in the management and direction of our nation's research enterprise. This year also saw the escalation of academic "pork barrel" amendments in which Congress earmarked funds for particular institutional research and facilities without the protections offered by competitive peer review of the projects' merits. This disturbing trend is understandable in view of the lack of an adequate program of support for research facilities construction and renovation, but the potential harm to science is enormous because such awards undermine the peer review process that has served so well, and divert funds to projects where relevance to program objectives that are in the national interest is unproven.

In another area related to research, there has been a surprising amount of congressional attention focused on the fate of fifteen primates that had been housed at NIH pending judicial review of the animals' future. They have been the subject of voluminous correspondence and congressional resolutions. The campaign to engage congressional interest for these animals is part of a well-orchestrated, strident, and aggressive movement to eliminate the use of animals in essential medical research. We are gratified that an appellate court decision has rejected the arguments of animal rights organizations concerning these animals. I hope that the year ahead, in which the National Institutes of Health celebrates one hundred years of federal support for the scientific investigation of disease, will provide many opportunities for us to reinforce the vital contributions that its research efforts as well as those of others make to the health of all individuals. Perhaps the coming year will also see a resolution of the nagging problems associated with the rising indirect costs of research. Continued failure to solve this vexing problem will be injurious to research and divisive to institutions.

In the past year we have seen Congress re-examine its commitment to support basic residency training under Medicare and Medicaid. This is not merely the result of the increasing national conviction that there is a physician surplus. It is also a response to the argument that patient care funds are inappropriate sources of support for an institution's educational activities. The education of novitiate physicians is a crucial component of our institution's missions, and financing for these activities must be assured. We must be prepared to defend the education of future health professions as a common good to which all society must contribute.

During the past year the Association published proceedings of special symposia it had sponsored on medical information science and clinical education. Both of these efforts had roots in the Association's important 1984 report on the General Professional Education of a Physician, and are evidence of the Association's continuing commitment to stimulate its members to review, refine and improve the process by which they educate young women and men for the profession of medicine. A key programmatic activity in this area during the next year will be consideration of the transition from medical school to residency. At a time when there are increasing local pressures on faculty members to provide income from clinical practice to support an institution's activities, it is an important responsibility of the AAMC to focus faculty attention on their educational mission and their obligations to students.

Assuring adequate levels of student financial assistance has long been an important priority of the Association and during the past year we implemented our own comprehensive loan program to guarantee loan capital for all enrolled medical students in good academic standing. MEDLOANS is a positive response by the Association to the increased difficulty of financing a medical education.

To assist its members, the Association continued its expanded Management Education Program, offering new seminars on alternative delivery systems and clinical evaluation. We have also undertaken, in conjunction with the Association of Academic Health Centers, a new effort to develop strategies for promoting academic medical centers and their special contributions to our nation.

The Association remains alert to the threats to the educational functions and fiscal well-being of teaching hospitals that are embodied in many legislative and regulatory proposals, particularly in the area of reimbursement. I am also concerned about the increasing fragmentation that I see in the teaching hospital community that occurs as hospitals try new methods of aggregating themselves as protection in a hostile environment that pays little attention to their special role in our society. I hope the AAMC continues as a forum where differences among institutions are not as important as the common missions of teaching hospitals to provide the highest quality of medical care, to educate future health professionals, and to serve as a locus for clinical research and a laboratory for innovations in health care technology and the delivery of services.

Leadership is the theme of the AAMC's 1986 annual meeting, and it appears that the coming year will challenge the Association to continue its demonstrated record of leadership on behalf of its member institutions. Challenges to this leadership may come from many quarters, and for us to enjoy continued success we will need to reinforce and improve our methods of communication, both between the AAMC and its members and among the Association's members. We are a membership organization, and can be effective in your behalf only if we hear and understand your needs. Improving this communication will be an important priority for my tenure at AAMC.

Robert G. Petersdorf, M.D.
President

Executive Council

Chairman
Virginia V. Weldon

Chairman-Elect
Edward J. Stemmler

Immediate Past Chairman
Richard Janeway

President
John A. D. Cooper*
Robert G. Petersdorf

Council of Academic Societies

David H. Cohen
William F. Ganong
Frank G. Moody
Virginia V. Weldon

Distinguished Service Member

Charles C. Sprague

Council of Deans

Arnold L. Brown
William Butler
D. Kay Clawson
Robert Daniels
William B. Deal
Louis J. Kettel
Richard H. Moy
John Naughton
Richard S. Ross

Council of Teaching Hospitals

J. Robert Buchanan
Spencer Foreman
Sheldon S. King
C. Thomas Smith

Organization of Student Representatives

Vicki Darrow
Richard Peters

*retired September 2, 1986

Executive Committee

Chairman
Virginia V. Weldon

Chairman-Elect
Edward J. Stemmler

Immediate Past Chairman
Richard Janeway

President
John A. D. Cooper*
Robert G. Petersdorf

Chairman
Council of Academic Societies
David H. Cohen

Chairman
Council of Deans
D. Kay Clawson

Chairman
Council of Teaching Hospitals
C. Thomas Smith

The Councils

EXECUTIVE COUNCIL

The Association's Executive Council meets quarterly 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 Council of Deans, Council of Academic Societies, Council of Teaching Hospitals, and the Organization of Student Representatives, the constituent components of the AAMC's governance structure.

Newly elected officers and the senior staff of the Association attended the traditional December retreat to consider policy issues and set priorities for the Association in the coming year. Discussion at the retreat focused on a number of issues related to undergraduate medical education including changes in the size and composition of the applicant pool, clinical education, and appropriate AAMC follow-up activities to its report on the General Professional Education of the Physician. In the area of graduate medical education, the retreat participants discussed financing, quality of the educational program, the transition from medical school to residency, and institutional responsibility for graduate medical education. Among the other topics considered were institutional policies on dealing with students with acquired immune deficiency syndrome, the practice of medicine by medical school faculty, the payment of indirect costs of research, pending legislation to authorize a new construction program for research facilities, and the appropriate role of the Liaison Committee on Medical Education in the review of the educational programs of foreign medical schools.

Many of the issues reviewed and debated by the Executive Council during the past year reflected the Association's traditional priorities in support of research and research training, student financial assistance, and adequate reimbursement for medical care in teaching hospitals.

A research issue in which Association members have an important interest concerns the payment of the indirect costs of conducting research. A number of congressional and administration proposals have been brought forward which would limit the reimbursement of such costs. The Association has sought to reconcile the differences among other organizations in this area, and the Executive Council endorsed the Association's role as a mediator, expressing its belief that any change in the method of indirect cost reimbursement should be made gradually and in consultation with universities and their faculties.

Federally-supported student financial assistance continued to suffer from budgetary constraints, and the Executive Council has been concerned about the availability of funds for financing students' medical education. In response to these concerns, the Executive Council approved the establishment of MEDLOANS, a new Association program to offer financial aid to medical students. In addition to providing access to federal programs such as Guaranteed Student Loans, Health Education Assistance Loans, and Auxiliary Loans to Assist Students, MEDLOANS offers a new private Alternative Loan Program at market rates, tailored to the particular needs of medical students.

Much of the Executive Council's attention in the patient services and medical care area was focused on Medicare reimbursement policies. The Executive Council strenuously opposed any freeze in Medicare payments to hospitals and also opposed any extension in the Medicare freeze on payments to physicians for professional services. The Council recommended that the prospective payment system be amended so that payments are based on a DRG-specific, blended rate of hospital-specific and federal component prices. The Association also supported establishing an adjustment to recognize the generally higher costs incurred by hospitals serving a disporportionate number of indigent Medicare patients.

The support of residency training under the Medicare program was an especially important issue in the past year. The Association recommended retaining explicit Medicare funding of graduate medical education for at least the number of years required to attain initial board eligibility in various specialities (to a maximum of five years) plus one additional clinical year for advanced specialty and subspecialty positions in hospitals in which the positions were supported by Medicare in 1984-85. The Association also en-

dorsed eliminating Medicare funding for residents who are not graduates of accredited medical or osteopathic schools located in the United States or Canada. The Association proposed a period of phase-in for implementing these recommended changes.

The Association also supported a recomputation in the resident-to-bed adjustment and a requirement that the Health Care Financing Administration update each hospital's published case mix index using data from the first year of prospective payment.

The Executive Council discussed a possible legislative move to incorporate the payments for hospital-based physicians such as radiologists, anesthesiologists, and pathologists, into the DRG hospital reimbursement program. It was concluded that the proposal was generally undesirable and that the AAMC should oppose it because of its potential harmful impact on teaching hospitals and clinical faculty relationships.

Strong efforts were underway in a number of jurisdictions to enact new legislation dealing with professional liability insurance. The Executive Council endorsed the concept of tort reform, citing the special needs of academic medical centers which use part-time faculty and the mobility of faculty members. The need for better discipline within the profession was also recognized.

There was a discussion of a report from the congressionally-mandated Task Force on Organ Transplantation which recommended that the diffusion of transplantation technology be regulated. Although the Executive Council supported the development of criteria to delineate quality standards for the provision of transplant services, it was believed that such criteria should be developed by professional societies and not by the federal government. The only limitations that should be placed on the performance of transplants should be related to the institution's ability to provide quality service and not to arbitrary political or geographic factors.

Tax reform legislation was reviewed by the Executive Council at several meetings. The AAMC supported the continued access of universities and hospitals to tax-exempt bond financing; although the Association was willing to accept some new restrictions on such financing, it opposed a proposed state-by-state cap on the annual volume of issuances and a cap on the total amount of outstanding tax-exempt bonds available to each university. The Executive Council also opposed provisions that would eliminate scholarships and fellowships from taxable income and would impose taxes on prizes and awards. The Association also communicated with its members on the impact of proposed changes relating to pensions, IRAs and the tax-exempt status of TIAA-CREF.

The Executive Council was asked to consider whether irregularities in the admissions process identified by AAMC staff should be reported to non-member institutions in other health disciplines and to licensing boards. The Council concluded that the AAMC would provide copies of completed irregularities reports to non-member health professions schools when there was reason to believe the subject was applying to the school and that reports would be provided to licensure bodies in response to requests regarding particular individuals.

At the request of the Organization of Student Representatives the Executive Council considered issues relating to the reporting of scores from the National Board of Medical Examiners. The Executive Council believes that the NBME should report scores to students and medical schools on a pass/fail basis only. Implementation of this recommendation will be discussed at the 1986 annual meeting.

The Executive Council makes extensive use of committees of AAMC constituents to guide its deliberations on key policy matters. During the past year the Council acted on reports from a number of such committees.

A steering committee on a project to evaluate medical information science in medical education was chaired by Jack Myers, university professor at the University of Pittsburgh. The committee report, which was approved in January, concluded that medical informatics is basic to the understanding and practice of modern medicine and that the field should be integrated throughout the medical education program. The report, which included a state-of-the-art review, was recommended for wide distribution.

J. Robert Buchanan, general director of the Massachusetts General Hospital, chaired an Association Committee on Financing Graduate Medical Education. The Executive Council endorsed the committee's recommendation that patient care revenues continue to be the principal source of support for graduate medical education, but that some limitations be established on training support. It was recognized that payment for residents in ambulatory teaching settings continued to be a problem needing attention by the AAMC.

The AAMC's Committee on Federal Research Policy had been charged with conducting a broad overview of policy issues related to the federal role in the conduct and support of biomedical research. The committee examined Association policy relating to the goals of the federal research effort, research manpower and training, research

infrastructure, research awards system, federal funding for research, and formulation of federal research policy. The committee was chaired by Edward N. Brandt, chancellor of the University of Maryland.

Sherman Mellinkoff, dean of the UCLA School of Medicine, chaired a committee to review the Medical College Admission Test, its use by medical schools in their selection process, the effects of this use on undergraduates and undergraduate institutions, and the Association's stewardship of the examination. The committee concluded that the MCAT is useful in helping establish minimum academic qualifications, and that the AAMC should continue its efforts to improve the understanding by undergraduate advisors and medical school faculties and admissions committees of the development of specifications and the preparation of test questions. The Committee also concluded that the Association had been reasonable in its stewardship of the program and not overly dependent on its income.

The Executive Council approved the establishment of a new ad hoc Committee on Strategies for Promoting Academic Medical Centers, which will be a joint activity with the Association of Academic Health Centers. This new committee is chaired by D. Gayle McNutt, director of communications at the Baylor College of Medicine.

Responding to concern from several quarters, including the Council of Deans and the Group on Student Affairs, the Executive Council has appointed a Committee on Graduate Medical Education and the Transition from Medical School to Residency, chaired by Spencer Foreman, president, Montefiore Medical Center. A preliminary report recommended that each institution develop common policies and procedures for all its graduate medical education programs, that institutional compliance with the ACGME's general requirements be enforced, that limitations be placed on electives students can take at other medical schools, that the evaluations presented in the dean's letter be improved, that the NRMP be used for selection of all residency positions, and that a new timetable be established for the NRMP and the release of school evaluations. This discussion draft will be the subject of a special general session at the 1986 AAMC Annual Meeting.

The Association's Finance Committee, chaired by Mitchell Rabkin, president of Beth Israel Hospital, began a long-term review of the Association's financial situation, including projections for income and expenditures in future years, and the Association's policies for management of its reserves.

In its role as a parent organization, the Executive Council has a responsibility for overseeing the activities and policy actions of a number of other organizations. A particularly critical issue was raised this year with respect to the participation of the Liaison Committee on Medical Education in the accreditation of foreign medical schools. The Executive Council believed that medical school accreditation as developed by the LCME was a uniquely American system for evaluating the quality of a medical education program in which peers voluntarily submit to a critical review by their colleagues. Even if the LCME had the resources to accredit the more than 750 foreign medical schools with graduates sitting for the ECFMG exam, the Council felt that the LCME's system of accreditation would not be transferable to other localities with different traditions and patterns for education, research, and the delivery of care. The Council also noted that the LCME had no particular expertise to develop standards which might be appropriately used to evaluate foreign schools. A second concern related to the enormous liability involved in the accreditation of hundreds of foreign medical schools and the inability for adequate legal protection to be assured, even through government indemnification. Instead of supporting an LCME role in the accreditation of foreign medical schools the Executive Council committed the Association to working with other concerned organizations to establish criteria for the evaluation of graduates of foreign medical schools and reaffirmed AAMC support for the development of a satisfactory examination of clinical competence for such graduates as a condition of eligibility for entry into accredited residency programs.

The Executive Council was asked to consider whether the Accreditation Council for Continuing Medical Education should be separately incorporated as a means of protecting parent organizations for legal liability. The Council felt that the guiding principle should be that if the activity was germane to the Association's mission, the AAMC should assume the attendant risks. It was suggested that the Association review its involvement in continuing medical education accreditation and other activities in relation to the Association's overall goals.

Two amendments to the general requirements section of the *Essentials of Accredited Residencies* of the Accreditation Council for Graduate Medical Education were brought to the Executive Council for action. The Council approved an amendment that would call for residency programs to foster understanding of medical ethics and provide instruction in the socioeconomics of health care and the importance of cost-effective medical practice.

There was spirited debate about a proposed amendment that would add to the accreditation standards a stipulation that adequate financial support for residents' stipends is an essential component of residency programs. Consideration of this issue included discussion of whether stipend support was essential for a program to be educationally sound or whether it was more related to issues of fairness and equity, and whether such a standard was appropriate for an accreditation document of this nature. The Executive Council supported a new amendment that states that "financial support of residents is necessary to assure that residents are able to fulfill the responsibilities of their educational programs."

The Executive Council and the Executive Committee are responsible for decisions relating to AAMC participation in court cases. The Association appears with a number of other scientific and educational organizations and scores of Nobel laureates on an *amicus* brief in *Edwards v. Aguillard,* a case related to a Louisiana statute on the teaching of evolution and creation-science. The brief argues that the science education of our school children should accurately portray the current state of substantive scientific knowledge and the premises and processes of science.

The AAMC had joined the American Hospital Association, the American Medical Association, and a number of other medical organizations challenging the government's "Baby Doe" regulations relating to the treatment of profoundly handicapped infants. In June the Supreme Court affirmed an Appeals Court decision invalidating the regulations which had required that the federal government be granted access to the medical records of infants for whom the parents had chosen not to seek treatment.

The Association and other related organizations had also filed an *amicus* brief with the Supreme Court on the constitutionality of state laws putting requirements on physicians with respect to abortions. The arguments in favor of the traditional physician-patient relationship prevailed.

The Association had also been an *amicus* in the University of Michigan's successful petitioning that there were not instances in 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 AAMC had also joined other educational associations in *Connolly v. Burt,* which involved an attempt by one physician to sue in the state to which a letter of evaluation was sent rather than in the state where the evaluating physician resided.

In April the Association united with 67 other scientific and academic organizations in filing an *amicus* brief in a case before the U.S. Court of Appeals to decide whether legal standing should be granted to animal rights advocates, allowing them to sue for custody of laboratory animals under state anti-cruelty statutes. The brief pointed out the benefits of animal research, argued that animal rights advocates or other private parties have no standing under either federal or state law to bring suit on behalf of laboratory animals, and emphasized the serious adverse consequences for both science and the judicial system that would result from a decision supporting the animal rights groups. The appellate court ruled against granting legal standing to these groups.

The United States District Court had found Viken Mikaelian and Multiprep in civil contempt of the court's injunctive order with respect to the AAMC's suit on copyright infringement on the MCAT. The AAMC was awarded $200,000 plus attorney's fees.

During the past year the Executive Council voted special recognition awards to Carolyne Davis, former administrator of the Health Care Financing Administration, Edward N. Brandt, former Assistant Secretary for Health, J. Alexander McMahon, retiring president of the American Hospital Association, and James H. Sammons, executive vice president of the American Medical Association.

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, the Finance 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 1987.

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 Health and Human Services Secretary Otis Bowen.

COUNCIL OF DEANS

Two major meetings dominated the Council of Deans' activities in 1985-1986. The Association's annual meeting in Washington, D.C. featured a program session for deans and a social event. The Council's spring meeting was held in Key Largo, Florida on April 2-5, 1986. The COD Administrative Board meets 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 are reviewed by sections of the deans brought together by common interest.

The Council's annual meeting program session discussed the proposed comprehensive examination of the National Board of Medical Examiners and problems in the transition between medical school and residency education. A panel moderated by L. Thompson Bowles, dean for academic affairs, George Washington University Medical Center, discussed the first topic. The panel featured Robert Volle, associate dean for basic sciences and research, University of Kentucky College of Medicine and chairman of the NBME committee developing the new examination; David Citron, president of the Federation of State Medical Boards; Richard Peters, chairman-elect of the Organization of Student Representatives; and Richard H. Moy, dean, Southern Illinois University School of Medicine. Arnold L. Brown, dean, University of Wisconsin Medical School, moderated a panel on transition problems. It featured a presentation by Norma E. Wagoner, chairperson of the Group on Student Affairs and associate dean for student affairs and educational resources at the University of Cincinnati College of Medicine. Co-authors of Dr. Wagoner's paper who provided commentary were Jack C. Gardner, associate dean for student affairs, UMDNJ-Rutgers Medical School; John H. Levine, assistant dean for curriculum, Medical University of South Carolina; and Paula L. Stillman, associate dean for curriculum at the University of Massachusetts Medical School. The annual business meeting featured an inspiring presentation by John A.D. Cooper, AAMC president, on the need to avoid divisions among Association members. The deans also heard updates on institutional policies on AIDS, the AAMC's medical student alternative loan program, the MCAT pilot project, investigations of the VA inspector general regarding conflict of interest, and reports from Association committees.

A new format at the Council of Deans spring meeting facilitated maximum interaction and participation of the deans on issues of importance. Discussion groups considered four topics: the attractiveness of medicine as a profession, institutional responsibility for medical student education, institutional responsibility for graduate medical education, and problems in the transition between medical school and residency. The meeting culminated with the approval of various recommendations emerging from the discussion sessions.

On the first topic, the deans recommended that the introductory marks of Spencer Foreman, president, Montefiore Medical Center, be used as a preamble to a strategy paper and action plan which place emphasis on pride in the profession and restraint from an attitude of panic. They also recommended the analysis of applicant pool data to seek trends within or among categories of schools. Individual school applicant pool data analysis and trends should be made available on a confidential basis, with special analyses of underrepresented groups. The Council affirmed that a strategy should be developed which assures that pre-medical advice through the official advisor system is accurate and based on current information and that demographically stratified opinion surveys should be conducted to characterize the present attitudes of high school and college students towards medicine. The deans further recommended the revision of the medical school admissions requirement handbook to emphasize opportunities in medicine. The deans encouraged all medical schools to analyze individual applicant pool data for negative factors to be corrected and positive factors to be emphasized. Finally, they stated that the AAMC and its members should emphasize the historic role of medicine as a socially responsible profession.

The deans reaffirmed their position as key to the implementation of institutional responsibility for medical student education. They viewed the call for more self-directed problem-based learning in the medical curriculum as appropriate and most productive in interdisciplinary courses. They called for a rotation of the primary responsibility for teaching so that in any year fewer faculty were involved with students to promote closer student-faculty interactions. Also, acknowledging that the examination drives the system, the deans called for more faculty examinations as opposed to discipline examinations, and ones that would involve problem-solving skills, technical skills relating to patients and other professionals, and the ability to handle stress. The deans suggested more shared accountability across departmental lines, especially clinical and basic sciences. Finally, they requested that the AAMC staff undertake an effort to identify valid criteria for measuring excellence in teaching.

The deans called for medical schools which had not already done so to assume a larger share of the responsibility for the governance of graduate medical education programs, and, as a corollary, that the AAMC role in graduate medical education be expanded. Medical schools and their teaching hospitals should form a common organization to govern each school's graduate medical education programs and deans and hospital directors should be directly involved in every residency

program review. The deans made a number of recommendations addressed to the problems in the transition between medical school and residency education. To ensure the continuity and quality of medical education in the third and fourth years, they resolved that dean's letters and transcripts should not be sent before October 1, that core clerkships should occur only in the student's own institution, that fourth year experiences should be carefully evaluated, and that every effort should be made to give up independent match systems and informal actions about residency selections. The deans further resolved that the AAMC advocate to the Liaison Committee on Medical Education the evaluation of these policies and practices as part of the accreditation process for all medical colleges, that the AAMC take the initiative in establishing an AMCAS-like system for residency application and selection, and that the NRMP manage the match for all applicants.

The Southern and Midwest deans, deans of community-based medical schools, and deans of private freestanding schools held various meetings throughout the year to discuss issues of specific interest to their members.

COUNCIL OF ACADEMIC SOCIETIES

The Council of Academic Societies represents academic and scientific societies from all basic and clinical disciplines. In 1985 three societies joined the Council, bringing the total membership to 82. The CAS convened two major meetings during 1985-86.

The annual meeting in October 1985 featured presentations on two issues of interest for medical faculty. The first was the future role of physician scientists in medical research. Gordon N. Gill, professor of medicine at the University of California, San Diego, stressed the importance of medical schools providing the research centers and communication pathways within which scientific discovery will flourish. He emphasized the need for an environment that allows physician scientists to pursue research opportunities freely, and warned that bureaucratizing research will discourage "the serendipity of science."

John W. Littlefield, professor and chairman of physiology at Johns Hopkins University, analyzed the changing role of the M.D. in scientific research. He described the importance of giving students a realistic view of medical research careers and ways to prepare early for such careers. He expressed concern that the growing number of M.D./Ph.D.s in research sends a message to medical students that a Ph.D. is necessary to do biomedical and behavioral investigation. Noting the increasing difficulty in conducting medical research on a part-time basis, Dr. Littlefield stressed that physician scientists can make important contributions in areas tailored to their strengths or as part of a team effort.

The second issue discussed by the Council was the recent challenges to and pressures on the peer review system. Ruth Kirschstein, director of the National Institute of General Medical Sciences, described the current grant award process and characterized some of the pressures on the peer review system. She said that the most significant problem is the lack of adequate funds, particularly in view of the increasing number of high quality research proposals submitted. She suggested that the dramatically lowered award rates have contributed to a loss of confidence in peer review on the part of the scientists. In addition, academic institutions that obtain funding for "big-ticket" buildings directly from Congress, thereby circumventing the peer review process, weaken the system. She urged scientists to join in reaffirming the importance of peer review as the foundation of biomedical research because it "provides the best advice about the scientific merit of competing grants."

Edward N. Brandt, chancellor of the University of Maryland, at Baltimore, described the current congressional and public concerns related to peer review and the ways in which scientific decisions are restricted by legislative or administrative actions. He reviewed some alternatives to the present dual-review system for grant awards, and concluded that peer review is "the best mechanism for the determination of scientific quality."

An extensive debate centered on the use of hospital patient care funds to support graduate medical education highlighted the business portion of the meeting. The Council reviewed the ongoing deliberations of the AAMC ad hoc Committee on Financing Graduate Medical Education. Concern focused on the possibility that pending Medicare legislation would severely limit or eliminate support for residents. The Council strongly urged the Committee to advocate the use of patient care revenues to support residency training of sufficient length to ensure that specialists in various disciplines are fully trained and to resist efforts to control the number of specialists trained through reductions in the federal funding for graduate medical education.

The CAS also heard a report on the investigation by the Inspector General of the Veterans Administration into possible conflict of interest for VA employees who accept any funds from pharmaceutical companies. The Council expressed concern over the confusions inherent in dual pro-

fessional standards where some forms of consulting are encouraged in university academic roles and discouraged under a much more stringent conflict of interest interpretation for those with any VA affiliation.

The Council considered the AAMC commentary on the GPEP report. This commentary, which was developed by a joint CAS-COD working group, addresses the major concerns and criticisms that have been raised with regard to the GPEP report and provides specific guidance on the implementation of the recommendations of the GPEP panel in selected areas. The CAS also reviewed some of the recent trends in medical school applications and endorsed the report of the AAMC-AAU Committee on the Management and Governance of Institutional Animal Resources.

The CAS spring meeting, which was held in Washington, D.C. March 26-27, included two panel discussions. The first panel, which was moderated by Edward J. Stemmler, dean of the University of Pennsylvania School of Medicine, addressed the future of faculty practice from the perspectives of medical school dean, hospital administrator, and faculty. This discussion focused on the effects of the changing practice environment in academic medical centers on the traditional education, research, and patient care missions. Among the issues raised were the increasing dependence of institutions upon practice income, concern over faculty appointments and tenure decisions, access of voluntary faculty to referral patterns and diagnostic specialty units, and the impact of cost-containment efforts on the care of the medically underserved.

The second panel, which was moderated by CAS Chairman David Cohen, SUNY-Stony Brook, reviewed the draft report of the AAMC ad hoc Committee on Federal Research Policy. Various CAS members of the committee reviewed the report's recommendations regarding the scale and scope of the federal investment in biomedical and behavioral research, the priorities of the federal biomedical research effort, the scientific review of research proposals, renovation or replacement of research facilities, and federal biomedical research training programs. The panel also discussed the committee suggestions to enhance the input from the scientific community into the formulation of biomedical research policy by the executive and legislative branches of the federal government.

Other items on the spring meeting agenda included the final draft of the AAMC Committee on Financing Graduate Medical Education, the alternate fiscal 1987 budget for NIH and ADAMHA developed by the Ad Hoc Group on Medical Research Funding, faculty concerns related to the effect of the current tax reform legislation on retirement annuity plans, and an update on the administration proposals related to the reimbursement of indirect costs for federally sponsored biomedical research.

The CAS Administrative Board conducts its business at quarterly meetings held prior to Executive Council sessions. In January, the Board discussed various issues related to the representation of individual academic societies within the Council and on the Administrative Board.

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 1985-86: the American Academy of Neurology, the American Neurological Association, the Association of University Professors of Neurology, the Child Neurology Society, and the American Federation for Clinical Research.

COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals held two general membership meetings in 1985-86. At the COTH general session held during the 1985 AAMC Annual Meeting, Richard M. Knapp, and James D. Bentley, director and associate director of the Department of Teaching Hospitals, shared the platform with Sheila P. Burke, deputy chief of staff, Office of the Senate Majority Leader. Drs. Knapp and Bentley focused on the future in "Looking Ahead at Academic Medical Centers," while Ms. Burke dealt with the present dilemmas of "Health Policy Directions in an Era of Budget Constraints." Dr. Bentley postulated that the academic medical center, when viewed as a social system faced with excess physician supply and hospital bed capacity, can manage change by emphasizing business practice and insurance functions, or by establishing disciplined and functionally interrelated clinical practices. In considering the historical development of the hospital and its relationship to physicians and insurers, present-day changes in hospital relationships, and implications for teaching hospitals in the years ahead, Dr. Bentley called for careful assessment of the strengths of the teaching hospital as the underpinning for successful adaptation.

Dr. Knapp considered the pace of change and the resulting escalation of events in the health care environment, calling on hospital CEOs to take time for reflection. Remarking on the past use of cross-subsidization to support the teaching hospital's multiple missions, he observed that the current climate appears to call for an impossible

alliance between cooperation and competition, especially in graduate medical education. While allowing for flexibility and changes in the field of health care delivery, Dr. Knapp cautioned that members not lose respect for the roots of the teaching hospital—a triumvirate of education, research, and patient care.

Ms. Burke provided a retrospective view of health policy decisions, presenting the deliberations of Congress and the administration by focusing on institutional providers of care, patients, and cost-sharing, and the individual physician. She warned that the overriding impetus for future federal decisions in the health care arena will continue to be the control of the deficit. Since the budget process lacks specificity, authorization committees must provide substantive amendments to budget-related legislation to allow practical and equitable implementation. She encouraged AAMC members to help Congress understand the complexity of the health care delivery system for knowledgeable decision-making.

The ninth annual spring meeting of the Council of Teaching Hospitals was held in Philadelphia, May 7-9, 1986, with over two hundred hospital executives attending. The meeting began with an evening in honor of John A.D. Cooper, including the noted political humorist Mark Russell. Presentations at the meeting focused on the impact of recent changes in health care reimbursement and on developments in medical technology, and their implications for the future. Stuart Altman, dean and professor of national health policy at the Heller Graduate School of Brandeis University and Chairman of the Prospective Payment Assessment Commission, opened the first session with an overview of the Commission's recent activities and recommendations. Emphasizing that ProPAC's two major responsibilities are to advise the executive branch and Congress on the update factor, and to help them to take advantage of new technologies, Altman stated that ProPAC's likely impact is on structural changes within the DRG system. Paul Gertman, vice chairman of CAREMARK, Inc., discussed developments in health care research, problems with DRG assignment, and adjustment for differences in severity of illness. Myles Lash, director of health care for Arthur Young and Co., discussed predicted trends in teaching hospitals and new issues and challenges. Al Zamberlan, director of the Great Lakes Region of the Veterans Administration, discussed the VA's experiences in resource allocation using DRGs. The session ended with a discussion by Richard Berman, former executive vice president of New York University Medical Center, of an approach to identifying the effects of key policy changes on different groups of teaching hospitals.

John S. Najarian, regents' professor and chairman of surgery, University of Minnesota Medical School, opened the second session with a description of recent advances in transplantation technology and related the ethical and economic issues. William Nolen, chairman of the department of surgery, Litchfield Clinic, also discussed the impact of new technology and changes in the health care delivery system on the practice of "small-town" medicine. R. Jack Powell, executive director of the Paralyzed Veterans of America, raised ethical issues about access for seriously disabled patients to advanced technology and medical care in an era of limited health resources.

The concluding session began as Robert Blendon, senior vice president of the Robert Wood Johnson Foundation, reviewed the implications of recent changes in the health care marketplace, and the need for increased awareness of the political climate in relation to health care legislation. The meeting ended with a panel chaired by Jack Shelton, manager of the employee insurance department, Ford Motor Company, who discussed the role of industry in managing health care for employees. David Chinsky, senior health economist for Ford, described the process by which the company identified abnormal medical care costs and initiated discussions with participating hospitals. Dennis Becker, vice president for planning and development at MEDSTAT Systems, Inc., concluded by speculating on future actions in the area of health care cost containment by employers.

During 1985-1986, the COTH Administrative Board met four times to conduct business and to discuss issues of importance and interest to COTH member institutions. Among the issues addressed by the Board were: Medicare payment of capital costs; Medicare payment for services provided to patients by radiologists, anesthesiologists, pathologists, and emergency room physicians; professional liability insurance legislation; tax reform; changes in graduate medical education training requirements; the recommendations of the National Task Force on Organ Transplantation; the AAMC role in the promotion of academic medical centers to the public; trends in medical school applicants; and the accreditation of foreign medical schools by the LCME.

The COTH Board joined the other AAMC Councils in a dinner in January honoring former HCFA Administrator Carolyne Davis. The Board held an evening session in April to exchange

views with Ed Mihalski, Deputy Chief of Staff for Health Policy of the Senate Finance Committee, and in September to meet with William Roper, Administrator, Health Care Financing Administration.

ORGANIZATION OF STUDENT REPRESENTATIVES

As during the previous year, 122 medical schools designated a student representative to the AAMC. Approximately 165 students, representing 96 of these schools, attended the 1985 annual meeting. The first day included regional and business meetings and a student leadership workshop. The plenary program, "From Apathy to Panic and Beyond: Actions to Shape a Better Medical Education," featured Kenneth Ludmerer, assistant professor of medicine, Washington University School of Medicine; Arnold Relman, editor of *The New England Journal of Medicine;* and Richard Moy, dean, Southern Illinois University School of Medicine. Dr. Ludmerer offered historical insights on the difficulties of accomplishing educational reform and urged students to pursue their ideals rather than becoming "rule of thumb" practitioners. Dr. Relman addressed the ethical contract that physicians have with society and argued that medical educators must better address changes in the practice environment so that students acquire the skills necessary to fulfill this contract. Dr. Moy concluded the program with suggestions to students about goals that they can influence. Examples were substitution of computer-storage for memory-storage and use of educational objectives and evaluation methods which are more comprehensive than those provided by the National Board of Medical Examiners. On Saturday afternoon there were workshops on patient interviewing as a preclinical student, computer-based medical education, curricular integration of health care cost awareness and ethics, promoting teamwork between medical students and nurses, preventive medicine, legislative affairs, and financing graduate medical education. Students also heard and questioned Patch Adams, founder of the Gesundheit Institute, on retaining humanistic ideals in medicine and building joyful relationships with patients. The students met in small groups to discuss "Critical Issues in Medical Education," a paper prepared by the OSR Administrative Board.

OSR offered two programs on Monday. "Aid for the Impaired Medical Student: A Program That's Working at the University of Tennessee" featured Hershel P. Wall, associate dean for admissions and students, University of Tennessee College of Medicine, and James Stout, medical student at Bowman Gray School of Medicine. John Stone, poet and director of admissions, Emory University School of Medicine, spoke on "Literature and Medicine: the Patient as Art."

A new feature of the OSR annual meeting, responding to the AAMC's report on the General Professional Education of the Physician, was the OSR Network. Since programs in place at one school interest students at other schools, OSR members completed a page asking for "Information Wanted" and "Information to Share." Following the meeting, a collated summary was distributed, with entries on curriculum, student activities, student health, public health, financial, and evaluation.

In addition to considering Executive Council agenda items of direct concern to students and residents and nominating students and residents to serve on committees, the 1985-86 Administrative Board completed and approved its "Critical Issues in Medical Education" paper. Two other projects on which the Board worked were a proposal to convene a symposium on problem-based learning and a survey of OSR members in conjunction with the Association of Teachers of Preventive Medicine to identify innovative teaching activities in health promotion and disease prevention. Two OSR Board members developed papers for publication in the fall issue of *OSR Report:* "The Medical Liability Problem" and "Keeping the Doors Open to Medical Education." The first summarized the contributions of the medical and legal professions, the insurance industry, and the health care consumer to the malpractice coverage problem. The second focused on disturbing trends in the access of minority and low income students to the medical profession.

During the spring, OSR met regionally with the Group on Student Affairs. While each region offered unique programs, three featured Patch Adams' "Elixirs of Life" program. The Central and Southern regions continued to produce regional newsletters containing progress reports of student-initiated projects and GPEP-related news. To cut travel costs, the southern and northeast regions produced student housing directories; students at 12 and 14 schools, respectively, volunteered their apartments for visiting students interviewing for residencies or taking off-campus electives.

National Policy

The national policy issues with the greatest potential impact on academic medical centers seem recently to have changed in character. In the past, the AAMC's major focus of concern was on legislation and regulation of relatively narrow and sharply defined scope, related to the programs of federal agencies in which our institutions have traditionally participated. Quite suddenly, more general issues, such as deficit reduction and tax reform that affect AAMC interests along with those of many others, have begun to dominate the federal agenda. For such problems, there are a host of contending interests. Global decisions, purportedly for the common good, are reached through bargaining among legislators advocating particular interests and special needs. More and more frequently, candid congressional staff tell their AAMC counterparts that a legislative provision of concern to academic medicine is marginal to the central thrust of a bill and therefore will be accepted or rejected, not on its intrinsic merits, but on its value as a bargaining chip. Not uncommonly these days, legislative proposals that significantly affect AAMC institutions surface unexpectedly in the form of language insinuated anonymously and without prior announcement or public consideration into lengthy bills. The latter have been crafted mostly behind closed committee doors and consumated rapidly, after brief floor consideration, often in the late hours of the waning days of a legislative period.

The enactment in December 1985 of the Balanced Budget and Emergency Deficit Control Act, familiarly known as Gramm-Rudman-Hollings (GRH), has overshadowed all national policy issues since. With it, the prominence of deficit reduction has taken a quantum leap in the legislative arena. Members of Congress, threatened by the huge and growing annual budget deficits of the last 4-5 years and frustrated by the stalemating of every reasoned and reasonable effort to modulate the phenomenon, suddenly and out of an apparent sense of exasperation adopted this radical proposal as a way to confront the problem.

GRH imposes target limits on the annual deficit, requiring that it be reduced in decrements of $36 billion per year, beginning with the FY 1986 budget and continuing until the deficit is erased in FY 1991. Each year, the Congress must enact whatever spending and revenue-raising measures are necessary to reach the prescribed deficit level. Should the Congress fail — a determination arrived at by statutorily defined processes carried out by the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) and verified by the General Accounting Office (GAO) — a completely automatic sequestration process goes into effect and culminates in a presidential order to require expenditures to achieve the target deficit level. The required expenditure reduction must be levied against a relatively small fraction of the federal outlays, since many high cost entitlement programs, e.g. social security benefits and Medicare, are either totally or partially exempt; half of the reduction must be borne by national defense accounts, half by non-defense programs. The uniform, non-discriminating, automatic and across-the-board sanction of GRH is widely seen as a judgment by the Congress that political considerations made it impossible to enact conventional budgetary legislation to reduce the deficit directly.

On January 15, 1986, scarcely one month after GRH's enactment, the OMB and CBO issued their expenditure and revenue projections for FY 1986 to the Comptroller General, estimating a deficit of $220.5 billion, $48.6 billion over the legal maximum. However, a specific provision of the act limited sequestration for FY 1986 to $11.7 billion. Accordingly, the OMB-CBO report called for a uniform sequestration of 4.9 percent and 4.3 percent, respectively, from eligible defense and non-defense programs. The report was duly verified by the GAO and the president's sequestration order was published on March 1, effective on April 1. The brunt of the non-defense cuts fell on discretionary spending, including many programs and activities vital to Association members. Funding for the National Institutes of Health (NIH) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was reduced by $236 million and $15.7 million, respectively, and Veterans Administration (VA) medical care lowered by over $117 million from the pre-sequestration FY 1986 appropriations.

The GRH law also contained a clause providing for expedited judicial review of its constitutionality. In December, 12 members of the House of

Representatives filed suit to have the law declared unconstitutional. In February, a special three-judge panel upheld the plaintiffs' claim that the role of Comptroller General in determining budget cuts was an unconstitutional infringement of the separation of powers doctrine. In June, the Supreme Court upheld the lower court decision, ruling it unconstitutional to grant "executive" branch budget control functions to the Comptroller General, an employee under the control of the legislature. This decision invalidated the spending reductions that took place under the March 1986 sequestration order. But the Congress voted by a wide margin in late July to reaffirm those spending reductions.

The Supreme Court ruling struck down only the provision of GRH that delegated to the Comptroller General the role of making the final specifications of the sequestration order to be issued by the president. However, anticipating the possibility of a successful court challenge of this aspect of the proposal, the drafters of GRH had inserted a fall-back alternative. Under it, a congressional Joint Committee on Deficit Reduction would report a Joint Resolution embodying the OMB/CBO sequestration recommendations; the spending reductions would only become law if passed by the Congress and signed by the president. This procedure would force each senator and representative to take a public stand on reductions, an action that heretofore has been assiduously avoided and is clearly not congenial. Not surprisingly, therefore, a number of constitutionally permissable proposals to restore the act's automatic nature have been floated: one would designate the Comptroller General an official of the executive branch; another, passed by the Senate in late July, would give OMB the power to implement the cuts, but reserve for the Congress the right to challenge the executive decisions. The issue has yet to be resolved.

The most desirable and rational way to achieve the target levels of deficit reduction is through the regular budget process. But as the deadline approaches for completing this process, the specter of the GRH sanction of sequestration has added enormous uncertainty about the future funding of federal programs of critical importance to AAMC members: those of NIH, ADAMHA, the Health Resources and Services Administration (HRSA), the Health Care Financing Administration (HCFA), and the VA.

President Reagan's FY 1987 budget request continued past efforts of the administration to reduce funding for domestic programs. While it met the GRH target of a deficit of $144 billion, the proposal requested spending levels for NIH and ADAMHA that were $424 million and $7.7 million, respectively, below the FY 1986 pre-sequestration levels, to provide funding for 5104 new and competing grants at NIH and 448 at ADAMHA, down from 6100 and 505 in FY 1986. The request also called for a reduction in Medicare payments of $3.94 billion under the current services level, the cost projection of FY 1986 program specifications into FY 1987. A large portion of the savings were to come from modifications in the reimbursement system for direct and indirect medical education costs, and from freezing physician fees. In addition, the reduction of $422 million below FY 1986 appropriation levels proposed for HRSA eliminated the health professions education programs.

The president's budget request for the Veterans Administration: reduced VA medical care funding by $172 million from FY 1986 pre-sequestration levels, with the bulk of the savings accruing from the imposition of a means-test for certain veterans with non-service connected disabilities and from a new requirement that private insurers reimburse the VA for the cost of care to insured veterans; slightly reduced the VA research budget; and slashed by 40 percent over current services levels its major construction program. The request for the Department of Education brought interest rates on loan programs more in line with market levels; the substantial savings to the government were offset by higher costs to students.

The president also asked that a total of $9.9 billion of FY 1986 spending authority be rescinded, including $77 million from NIH, $40 million from ADAMHA, $269 million from HRSA, $22 million from the Centers for Disease Control, and $7 million from Medicaid program management. Congress, however, failed to approve these proposals within the required 45 day time limit and they died.

After the Senate Budget Committee and the full House of Representatives formally rejected the president's budget, work on a FY 1987 Congressional Budget Resolution began in March. The Senate completed action first, passing its version on May 2. The Democratic House, reluctant without Republican commitment to initiate the revenue increases many claimed were necessary to meet the GRH deficit targets, waited for Senate action prior to passing its Budget Resolution on May 17. The final compromise budget package, passed on June 26, sets aggregate expenditures at a historic peak of almost $1.1 trillion in FY 1987, with an estimated deficit of $142.6 billion, ostensibly $1.4 billion below the GRH limit. The resolu-

tion limits defense expenditures to just over $292 billion, but creates a separate "reserve" fund of $7 billion which the president may tap, as long as both he and the Congress are willing to offset the increase by new revenues or reductions in non-defense expenditures. Revenues are raised only by $6 billion over the baseline for FY 1987, a substantial decrease from original House and Senate plans. For health programs, the resolution: adds $600 million in budget authority over post-sequestration levels to discretionary health programs in FY 1987; boosts Medicaid funding for infant mortality programs, for coverage of the elderly poor and to help states adversely affected by delays in the updates of federal matching rates; assumes certain savings in federal employee health benefits; calls for savings of $550 million during the coming fiscal year through Medicare provider payment reforms; and adds $250 million for future increases in the hospital deductible. For education programs the conference agreement restores most programs to the FY 1986 appropriated level.

Although extreme pressure to hold down expenditures was placed upon the Appropriations Committees, support for biomedical and behavioral research remained high. At hearings before both House and Senate Labor-Health and Human Services-Education appropriations subcommittees, AAMC witnesses urged that "the federal government must follow the policy that continuous steady investment in research and education is an investment in our country's future. This policy should remain invariant whatever the vagaries in the economy." They endorsed the recommendations of the Ad Hoc Group for Medical Research Funding that the appropriations for the research and research training programs of NIH and ADAMHA should be no less than $6.079 billion and $465 million. They also urged that health manpower programs be financed at least at current services levels. It was noted that in the research arena, the AAMC-supported levels of funding would provide only very modest program growth over current services levels and would be only minimally responsive to scientific opportunities. Student assistance was justified as necessary to guarantee socio-economically disadvantaged applicants access to medical education in the face of rapidly rising tuitions and other educational costs.

The House passed its FY 1987 appropriations bill for the Departments of Labor, Health and Human Services, Education and related agencies on July 31. NIH fared extremely well, receiving a proposed funding level of over $6.153 billion, an increase of $893 million over the post-sequestration FY 1986 level and $1.2 billion over the president's request. The ADAMHA research appropriation cannot be estimated because the House deferred appropriations for certain research programs whose expired authorizations await renewal. However, National Institute of Mental Health (NIMH) research was increased to $229 million, $28.6 million over the FY 1986 post-sequestration level, while NIMH research and clinical training each got small additions.

In early August, the Senate Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee approved a bill detailing NIH and ADAMHA funding for FY 1987. Funding for NIH was pegged at $6.080 billion, an increase of almost $811 million over last year's post-sequestration level. ADAMHA research and research training were proposed to be funded at a combined level of $462.7 million. Shortly thereafter, the full Appropriations Committee approved this markup without change.

Continued strong support of medical programs under the Veterans Administration was also advocated by AAMC witnesses testifying before the House and Senate Appropriations Subcommittees on HUD-Independent Agencies. The Association articulated its concern about the Reagan Administration's calls for substantial funding and personnel reductions in these programs for FY 1987 which, coupled with a newly enacted means-test and GRH reductions, raised the possibilities of a substantial shrinkage of the VA medical care system and a reduction in the quality of care at just the time when the VA's medical mission should be increased to meet the growing demands. To ensure the continued vitality of the VA medical care enterprise, the Association recommended the FY 1987 appropriation be at least at the current services level of $9.7 billion for medical care and $193.5 million for research programs.

In late July the House Appropriations Committee adopted an FY 1987 funding measure for the VA that would boost its medical care account by 4 percent from last year's level to $9.5 billion, and increase its research budget substantially to $193.9 million. The research increase was welcomed by many investigators who had feared that the VA research budget would be slashed to the $181.1 million level that the FY 1987 Budget Resolution assumed.

In what had to be one of the longest struggles in recent memory between House and Senate negotiators, Congress finally approved the Consolidated Omnibus Budget Reconciliation Act (COBRA). The measure, originally introduced to

make statutory changes necessary to effect compliance with the FY 1986 Congressional Budget Resolution passed in August 1985, bounced back and forth between the two bodies until a Senate-backed version was finally adopted on March 20, 1986. COBRA contained a number of provisions of great concern to AAMC members that: increased DRG prices by 0.5 percent; added a third phase-in year for the prospective payment system, delaying the transition to a national standard; reduced the basic level for the indirect medical education adjustment to 8.1 percent and moderated the influence of the rising resident-to-bed ratios; increased by one percent the direct medical education pass-through payments, with future changes tied to variation in the CPI; limited full Medicare support for residents to the number of years necessary to qualify for initial board eligibility plus one, but not to exceed five, with 50 percent support thereafter; and continued the freeze on payments to physicians, except to those who are currently "participating."

A Council on Graduate Medical Education to make recommendations on physician specialty distribution was also established by COBRA. This proposal had been strongly opposed by AAMC when it was originally introduced on the grounds that it would establish a mechanism that might encourage government intrusion, by legislation or regulation, into highly complex areas more appropriately left to market forces. The Association expressed doubt that such a Council could predict with accuracy future health care needs, or the optimal distribution of physicians among medical specialities; however, in attempting to carry out such a task, the Council's actions could wreck havoc with teaching hospitals which vary greatly in patient mix and, thus, in the types of residencies they can offer.

The traditional process for the review and award of federally-funded research grants was dealt another blow with the passage on June 24 of the Urgent Supplemental Appropriations for FY 1986. Contained in the final conference agreement was language mandating the Department of Defense to award approximately $55.6 million in research and construction funds to nine specified universities for projects that had never undergone peer review for scientific and technical merit or for relevance to federal program goals. Earlier, during Senate floor debate on the issue, an amendment, strongly supported by the AAMC, to delete the "pork barrel" language was approved; but almost identical language was reinserted by the House conferees and a second attempt in the Senate to strike the objectionable provision failed.

Almost as dominant as budgetary matters on the legislative agenda of the 99th Congress were actions to overhaul the federal income tax laws. Identified by President Reagan as the highest legislative goal of his second term, tax reform legislation has run a turbulent course during the past year.

As prescribed by the constitution, the House began the tax reform process. The Ways and Means Committee held hearings on tax reform legislation during the spring and summer of 1985, marked up the bill in closed session in October 1985, and then sent it to the House floor in December. A dramatic last-minute appeal from President Reagan, asking House Republicans to support the bill — not because of its merits but to keep the process alive for "perfection" in the Senate — saved it from almost certain defeat. A number of provisions in the House legislation turned out to be highly inimical to the best interests of the medical education and research community.

On the Senate side, action on tax reform legislation came in two distinct phases. The first was the markup of a measure formulated by the staff of Senate Finance Committee Chairman Robert Packwood. As markup advanced, the Committee soon discovered itself adding numerous tax preferences to the bill, generating $29 billion less in revenue over five years than in current law, and seriously violating President Reagan's dictum that any bill must be "revenue neutral" to garner his support. Senator Packwood abruptly cancelled further markup on the bill. By the time the Committee reconvened, he had embraced a radically different tax plan that embodied what most consider to be the principles of true tax reform. The plan retained many preferences in the current tax code relevant to the academic health community. The Senate passed the bill in late June with only three dissenting votes.

Starting from very divergent positions on tax reform, House and Senate conference committee members began meeting in early June to develop a compromise revenue bill. After long and acrimonious debates, often bogged down by efforts to protect tax advantages for home-state industries and concerns, a final agreement emerged on August 18th that embodied the most sweeping changes in tax structure in over 40 years. The conference proposal dramatically altered current tax rates, deductions, and exemptions. But it also profoundly reformed the assumptions underlying the use of the tax code as an instrument to effect changes in social policy.

Included in the far-ranging reform package were substantial modifications in many tax provi-

sions of vital concern to AAMC members. On the issuance of tax-exempt bonds, non-profit, i.e., 501(c) (3), organizations would not be subject to any state volume cap, but non-health care institutions would be limited to an individual cap of $150 million in outstanding bonded indebtedness. The amount of untaxed appreciation on property given as a gift and claimed as a deduction would be subject to an alternative minimum tax. Scholarship or fellowship awards for degree candidates in excess of the amount paid for tuition and required equipment would be considered taxable income. For pension plans, the bill would: allow a distinction to be made between faculty and non-faculty employees in the offering of retirement options by academic institutions; limit annual individual contributions to so-called 403 (b) tax-sheltered annuity plans to $9,500 with an overall contribution ceiling of $30,000; restrict annual contributions by employees of non-profit firms to Sec. 457 (unfunded deferred compensation) plans to the lesser of $7,500 or one-third of total compensation; constrain contributions to so-called 401(k) plans to $7,000 per year; permit full deductions for IRAs only for those not covered under an employer-sponsored retirement plan and earning less than a certain amount; and allow only the pension (and not the insurance) business of TIAA/CREF to remain tax-exempt. The value of faculty housing would be excluded from income, if rent paid to the institution exceeds five percent of the appraised value of the dwelling. The tax credit for research and development activities would be extended through the end of 1988 at 20 percent; and a 20 percent tax credit would be applied to corporate cash expenditures for university basic research, above a specified floor. Consumer interest, including interest on student loans, would no longer be deductible under the plan.

Many members of the House and Senate — who must approve the final plan before it becomes law — were quick to laud the conference agreement, as was President Reagan.

Legislation reauthorizing and setting spending limits on many programs important to the AAMC's constituency was enacted during the 99th Congress. One of the most important and controversial was the measure reauthorizing programs and activities at the National Institutes of Health. Included in the compromise House-Senate legislation were provisions that: created a new National Institute for Arthritis and Musculoskeletal and Skin Diseases and a National Center for Nursing Research; recodified Title IV of the Public Health Service Act to include delineation of specific authorities of the NIH Director, the establishment of the position of an NIH associate director for prevention, and the stipulation of the composition of national advisory councils; capped NIH administrative expenses; and imposed a long list of other mandates on NIH.

President Reagan vetoed the legislation on the grounds that it would adversely affect the pursuit of research excellence at NIH by adding numerous unnecessary administrative and program burdens, establishing unneeded new organizations, and imposing a uniform set of authorities on all research institutes. The AAMC supported the veto not only for the reasons cited in the veto message but because the cumulative impact of the bill constituted a major intrusion by government into the conduct of scientific research, a position reflecting the Association's consistent advocacy of maximum managerial and administrative flexibility at NIH. The veto was overridden in November 1985.

Agreeing last October to compromise legislation, the House and Senate renewed currently-funded health manpower programs in Title VII for three years. Although he had pocket vetoed almost identical legislation after the 98th Congress had adjourned, the president presumably felt that, in the face of the overwhelming support for the measure shown in both the House and Senate, another veto would be futile, and so signed the measure into law. For FY 1986, overall spending ceilings were set at FY 1985 appropriations levels; over the subsequent two years, program levels increased by an amount approximately one-half of the projected inflation level. No authorization was included for new federal capital contributions to the HPSL program; therefore, institutions will have to rely on their current revolving funds, at least for the next three years.

A number of major programmatic changes were also enacted in the reauthorization measure, especially for the Health Education Assistance Loan (HEAL) and Health Professions Student Loan (HPSL) programs. Males of relevant age will have to certify registration with the Selective Service System in order to be eligible for these loans. In addition, HPSL is modified to apply the National Direct Student Loan (NDSL) program delinquency formula to the program, allow larger penalties for late payments, and permit HHS to attempt collection on defaulted loans. HEAL program changes include a reduction of maximum interest rates on loans to 91-day T-bill rate plus three percent, a limitation of front-loaded insurance premiums to a maximum of eight percent if there is need for an increase, and a requirement that HEAL checks be issued jointly to the student

and the academic institution. The new law also mandated an annual set-aside of 20 percent of the Health Careers Opportunity Program (HCOP) appropriation in order to provide stipends of not more than $10,000 to students of exceptional financial need at schools of medicine, osteopathy, or dentistry.

For the last half decade, the role of animals in research has been a source of continuing controversy and ongoing debate, pitting the biomedical and behavioral research community against a small but vocal band of animal welfare/animal rights activists. After nearly four years of often acrimonious hearings, debates, discussions and negotiations among many parties holding various positions on the relevant issues, animal welfare legislation emerged in the 1985 farm bill and the NIH reauthorization. Neither is expected to seriously impede the progress of research, except to the extent that implementation may increase the cost of conducting it. The farm bill amended the Animal Welfare Act to require: new and stricter standards for animal care and use; more comprehensive reporting on compliance; training for all personnel involved in research with animals; establishment of at least one institutional animal committee at every institution, with membership and responsibilities clearly prescribed; exercise of dogs; an environment to promote the psychological well-being of primates; and consultation between Department of Health and Human Services and Department of Agriculture Secretaries to avoid conflicting regulations. The NIH renewal legislation contained less comprehensive requirements than did the farm bill; it essentially codified Public Health Service animal care policy. Among the important provisions in the law are a mandate that HHS issue guidelines for the care and treatment of animals in research, a requirement to establish animal care committees at all institutions receiving NIH funding whose research involves animals, stricter assurance requirements from research applicants that animal care guidelines are being met and an authorization to the NIH to suspend or revoke awards for failure to comply with guidelines. Identical provisions are also included in the 1986 ADAMHA renewal bill.

No fewer than six pieces of legislation dealing with animals in research have emerged in the 99th Congress including one measure to prohibit the use of NIH funds for the purchase of pound animals for use in research and another to grant legal standing to animal rights groups to sue the Animal and Plant Health Inspection Service for failing to enforce the Animal Welfare Act.

The past year has witnessed extensive work on a five-year reauthorization of the Higher Education Act, which includes programs indispensable to medical students. Title IV programs — the Guaranteed Student Loan (GSL), the National Direct Student Loan (NDSL), and ALAS/PLUS Loan — provide almost 50 percent of all aid received by medical students. The House version of the legislation embodied substantial modifications to current law as advocated by AAMC and other organizations representing graduate and professional education, including a needs analysis test for all GSL applicants and increases in the annual graduate and professional GSL and student ALAS/PLUS loan limits to $8,000 and $4,000, respectively. It also renewed authority for loan consolidation, and created a graduate fellowship program in areas of national need. During the floor debate, the House approved amendments restoring the five percent origination fee that had been eliminated under the version reported by the Education and Labor Committee and imposing a performance standard on foreign medical schools as a condition for participation in the GSL program.

The Senate Labor and Human Resources Committee in April approved HEA legislation raising the funding ceiling in FY 1987 to $9.7 billion, almost 13 percent over the previous year's appropriations, but almost $930 million below House-passed legislation. The bill also embodied a provision lowering the yield to lenders on GSLs to the 91-day T-bill rate plus 3 percent, stricter criteria for establishing the independence of students applying for assistance, an increase in the annual GSL limit to $7,500 for graduate and professional school students, an increase in the yearly ALAS/PLUS maximum to $4,000, and a loan consolidation provision under which HPSLs were included and HEALs were authorized to be repaid simultaneously with consolidated loans.

During floor debate on the Senate measure, an AAMC-backed committee amendment was adopted, requiring that for any foreign medical school to participate in the GSL program at least 75 percent of its students must be citizens of the country in which it is located. This differed from the cognate provision in the House bill: for a foreign medical school to be eligible to participate in the GSL program, at least 90 percent of the U.S. nationals matriculated therein must have scored in the top quartile of an approved medical college admissions test; and 50 percent of those who graduated must have passed an examination administered by the Educational Commission for Foreign Medical Graduates (ECFMG).

By the time Congress adjourned for the Labor

Day recess, House/Senate conferees on the HEA bill had reached tentative agreement on a number of issues including: a compromise provision lowering the yield to lenders on GSLs to 91-day T-bill rate plus 3.25 percent; increases in the GSL and ALAS/PLUS to $7,500 and $4,000 annually; setting GSL interest rates at eight percent in the first four years of repayment, ten percent thereafter; adopting the Senate's provision of a continuance of five percent GSL loan origination fee; loan consolidation for repayment of HPSLs along with administrative consolidation for HEALs; adoption in principle of a needs analysis test for all GSL applicants; and liberalization of the criteria for independency applied to graduate and professional students. Agreement was also reached on the participation of foreign medical schools in the GSL program; regrettably, the conferees elected to adopt both a modification of the AAMC-backed position in the Senate legislation and a modified version of its House counterpart. To be eligible to apply for GSL participation, a foreign institution must meet one of two requirements: either 60 percent of the school's students must be nationals of the country where the school is located, or the U.S. students (presumably graduates) of the institution must have achieved at least a 45 percent pass rate — increasing to 50 percent after two years — on the ECFMG examination. While disappointing that the original Senate provision was not adopted, it is encouraging that Congress has taken action to establish more reasonable policies on the issue. Conferees, however, were still bogged down on the bill's total price tag, and a number of other issues had yet to be resolved. Convergence and agreement are imperative; unless the HEA is renewed before the end of the 99th Congress, the implementation of improvements in current law could be delayed for as long as a year, causing severe hardship for medical students.

Legislation reauthorizing the Orphan Drug Act to promote the development of therapeutic agents for rare diseases was signed into law by President Reagan in August 1985. The law authorizes $4 million in grants in FY 1986 for the development of orphan drugs, and provides a seven-year market exclusivity period in order to create incentives within the pharmaceutical industry to develop and market these drugs. Also created is a 20-member National Commission on Orphan Diseases to monitor the progress toward goals of the legislation. In 1986 a provision granting orphan status to all human vaccines in order to create incentives for their continued development and availability was added to House legislation designed to create an out-of-court, no-fault compensation system for nearly two dozen common vaccine related injuries. This system, to be funded through an excise tax on vaccines, would cap pain and suffering awards at $250,000, eliminate punitive damages, and limit amount of lost earnings claimed as a result of an injured child; if the plaintiffs are not satisfied with the out-of-court award, they would have 90 days to file a civil suit, with no limit on pain and suffering or damage awards.

Of continuing interest to the academic health community is the problem of an aging infrastructure at our nation's research facilities. During the first session of the 99th Congress, legislation was introduced in the House to create a ten percent set-aside from the university research and development budgets of the six largest research funding agencies to fund facilities construction and rehabilitation projects. The program would be authorized for ten years, with the set-aside provision to begin in FY 1988 after a single year ten percent increase in each agency's authorization level, earmarked for facilities construction, in FY 1987. Out of the total set-aside at each agency, 15 percent is to be further earmarked for awards to "emerging" universities. Concerns that the bill's ten percent set-aside would not consist of new funds but instead would be taken from current research funds were magnified with the passage of the GRH Act late in 1985. The possibility that there would be no real growth in federal research spending in the near future substantially dampened enthusiam for this proposal.

The need to modernize research facilities was also the subject of a conference jointly hosted by the National Science Board, the White House Office of Science and Technology Policy, and the Government-University-Industry Roundtable at the National Academy of Sciences. As its report stated, "The conference was not designed to adopt consensus-based recommendations. The participants were searching for a comprehensive set of approaches that would meet facilities needs on a continuing long-term basis, recognize the diversity among research institutions and disciplines, and allow for the establishment of new research capabilities as well as the maintenance of existing strengths." Among the identified potential action items for the federal government were acceleration of indirect cost recovery, provision of credit support through loans, and direct federal funding of a construction program. Also identified were action items for state governments and for research institutions.

In early June, the Office of Science and Tech-

nology Policy (OSTP) published in the *Federal Register* a proposed "Model Policy for the Protection of Human Subjects in Research" to be adopted by the 20-plus federal agencies involved in the support, conduct or regulation of research involving human subjects. The proposed model policy is the OSTP's response to the First Biennial Report of the President's Commission on Ethics in Medicine and Biomedical and Behaviorial Research, and is based heavily on the existing DHHS regulations on human subjects promulgated in 1981. In its comments, AAMC praised the objectives of the proposed model policy to promote uniformity across all federal agencies, to recognize the differences among research institutions across the nation, and to allow institutional discretion in formulating local solutions to individual problems. AAMC took serious exception, however, to the proposed deletion of the current 60-day grace period between the time an institution submits a grant application to an agency and the institutional review board (IRB) certifies its approval of the project. The deletion of the grace period would create extreme hardship for grant applicants, research administrators and the IRBs, delay potentially promising research, and create unseemly pressure for IRB approval. AAMC also expressed concern that the Food and Drug Administration would not be required to adhere to the self-assurance system, and therefore will be able to continue its inspections to assure compliance.

Although the Association succeeded in a number of its efforts during the past year, there are many problems yet to be resolved. Effective advocacy for the highest priorities of the AAMC constituency on the national policy agenda — generous support for biomedical and behavioral research programs, adequate student financial assistance programs, and equitable reimbursement policies in academic medical centers for health care — must continue to be pressed, despite federal financial retrenchment.

Working with Other Organizations

The two highest elected officials and the chief executive officers of the American Medical Association, the American Hospital Association, the Council for Medical Specialty Societies, the American Board of Medical Specialties, and the AAMC serve on the Council for Medical Affairs. During the past year, the CFMA served as a forum for these important private sector health organizations to exchange views on such topics as assessment of clinical skills of foreign medical graduates, tax reform legislation, tort reform, integration of hospital and physician payments, use of animals in laboratory research, and international graduate medical education.

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, jointly sponsored by the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges, has documented substantial change in U.S. and Canadian medical schools since its formation in 1942. The primary responsibility of the LCME is to attest to the educational quality of accredited programs, directly serving the interests of the general public and of the students enrolled. Thus, the process of accreditation is designed to determine the achievement and to certify the maintenance of minimum standards of education.

Historically, licensing bodies in the United States and Canada accept the M.D. degree from a program accredited by the LCME as a prerequisite for licensure. The process of evaluation and accreditation by the LCME assists institutions in determining effective allocation of their efforts and resources. Survey teams provide periodic external review, identifying areas requiring increased attention, as well as areas of strength and weakness. The LCME serves the public interest by encouraging institutions with accredited programs leading to the M.D. degree to support, to the extent of their available resources, other educational programs, including graduate and continuing physician education, allied health education, graduate education in the biomedical sciences, public health, and research. In 1985, new standards for accreditation of M.D. degree programs were adopted by the LCME and approved by its sponsors. The ongoing implementation of these standards, defined in *Functions and Structure of a Medical School,* allows the LCME to continue its role in maintaining and enhancing 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 programs.

In 1985 there are 127 accredited medical schools in the United States, of which one has a two-year program in basic medical sciences. 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, the indictment and conviction of the individuals involved, and greater suspicion of proprietary schools. Moreover, the percentage of foreign medical graduates receiving residency appointment is decreasing, due in part to the fact that the number of students graduating from U.S. medical schools 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 increased the scope of its responsibilities by initiating the accreditation of subspecialty programs in internal medicine and pediatrics. Accreditation is only accorded to subspecialty programs conducted in conjunction with a program in the primary specialty. Nevertheless, this brings

over 2,000 programs under the ACGME's accreditation authority. The appeals process for programs sustaining adverse accreditation decisions was streamlined and a training program was established for members of appeal panels. A revision of the general requirements section of the *Essentials of Accredited Residencies* stating that all programs should provide instruction in ethical issues, in the socioeconomics of health care and in the importance of cost-effective medical practice was approved by the ACGME and ratified by its sponsoring organizations.

During this past year one of the major challenges for the Accreditation Council for Continuing Medical Education was clarifying the procedures for treating "enduring materials," such as "printed, recorded, or computer-assisted instructional materials which . . . constitute a planned activity of continuing medical education." Guidelines were prepared to assist sponsors to comply with the ACCME *Essentials for Accreditation of Sponsors of CME.* The first formal appeal of an ACCME decision led to some revisions in the procedure for reconsideration and appeal of adverse accreditation decisions.

The American Board of Medical Specialties, in response to the Association's concern about autonomous decisions by specialty boards to lengthen training requirements or otherwise impose additional resource demands on teaching hospitals, established a process to facilitate broad input by the medical education community before certification changes are adopted. An open forum will be convened by the ABMS within 180 days before the adoption of changes by a member certifying board.

Stimulated by the Association's 1981 recommendation that graduates of medical schools not accredited by the LCME be required to pass an examination of their clinical skills through direct observation, the Educational Commission for Foreign Medical Graduates began pilot testing an examination program for this purpose in 1985. The ECFMG plans to continue development of this "hands on" clinical examination in 1987 but has not yet decided whether the exam will become a part of its certification process.

For the fourth consecutive year, the Association provided the primary staff support and played a substantial role in the promotion of the Ad Hoc Committee on Medical Research Funding that seeks optimal appropriations for the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. As in the earlier years, the coalition of approximately 150 organizations has recommended funding levels for the two agencies that the Congress has received as well justified and highly appropriate, thus displaying to the legislators a broadly-based dedication to a common goal.

In another research-related area, the Association has worked closely with other scientific and educational organizations in continuing to strengthen the capabilities of the National Association for Biomedical Research for the primary effort to maintain the availability of laboratory animals for research, education and testing. The increased aggressiveness, sophistication and financial strength of the animal rights movement have required a series of collective activities, ranging from participation in legislative battles to opposing litigation that would grant legal standing to organizations to sue for custody of laboratory animals under state anti-cruelty statutes. The Association was involved in most of them.

The Association participates 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's Executive Committee meets periodically with its counterpart in the Association of Academic Health Centers. The organizations regularly exchange information and collaborate on programs such as an ongoing study of university ownership of teaching hospitals and a committee to develop strategies for the promotion of academic medical centers.

Education

Improving medical education is a high priority for the Association and its constituents. This is evidenced by the focus of the Council of Deans 1986 spring meeting on the attractiveness of medicine as a profession, institutional responsibility for medical student and graduate medical education, and transition from medical school to residency education. There is a growing consensus that medical student education is too fragmented and in many schools lacks a unifying authority. Greater interdisciplinary cooperation in program development and student evaluation is necessary with deans assuming primary academic responsibility and authority. One outcome of the deans' discussions has been the development of a project to identify and reward excellence in teaching.

The Executive Council appointed an ad hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency in response to concerns about problems in moving between medical student and resident education. The committee, recognizing the need for encouraging discussion of key issues among all who are responsible for medical student and resident education, developed a working document that has been widely distributed for discussion and comment. The committee's key recommendations are that: the ACGME establish an institutional review committee to determine whether institutions sponsoring graduate medical education programs are in compliance with the general requirements section of the *Essentials of Accredited Residencies;* students take clinical electives at other institutions only after completing their required clerkships at their own schools; written evaluations of students' performances be more candid and describe weaknesses as well as strengths; residency programs not encourage students to take electives in their programs for making selection decisions; the National Residency Matching Program change its timetable to announce matching results on April 1; student evaluations not be provided to program directors before November 1 of the senior year; and negotiations be undertaken with specialties currently holding early matches to have these specialties use the NRMP. These recommendations are the topic of a special general session at the 1986 annual meeting.

The 1985 Conference on the Clinical Education of Medical Students cast a strong light on the need for moving clinical education from the current heavy dependence on hospitalized patients to more diverse clinical settings. The increasing complexity of the clinical problems of hospitalized patients and policies to shorten hospital stays make it difficult for students to acquire basic clinical skills in hospital clerkships. Greater use of ambulatory care settings for education must be developed. The Association is planning a symposium on the problems that occur when basic clinical education is given in ambulatory clinics and how they can be resolved.

The Association's Clinical Evaluation Program is entering a new period emphasizing the dissemination of the self-assessment materials and literature evaluations developed in the project's earlier phases. The pilot schools will continue to be a resource as insights gained from the project become available to the entire membership. The Association also plans to incorporate the project's findings into other ongoing AAMC projects.

Clinical evaluation continues to be an important topic for the Group on Medical Education. One of the 1986 annual meeting sessions will focus on experimental efforts to assess student performance against the clinical competencies identified by faculty as implicit in the awarding of the M.D. degree. The session will review the experience of three institutions in depth and explore the practice at nine other schools.

In its continuing efforts to reinforce the recommendations from the General Professional Education of the Physician Project Report, the GME has undertaken several projects to facilitate educational progress review and the development of a program of change. One instance involves the development of guidelines for instituting change and the preparation of scenarios for developing skills in dealing with change. The GME Task Force on the Review of Curricular Innovations is developing a compendium of educational innovations that will include descriptions and reviews of each according to guidelines developed and tested previously by the Task Force.

The deans for curriculum or academic affairs meet regularly to improve their expertise and skills in the performance of their roles. A proposal to develop a formal workshop program on facili-

tating educational change on an institutional basis builds on the key role of the curriculum dean in managing such change.

The essence of almost all GME activities is providing forums for the exchange of information and material to improve medical education. One of the most efficient mechanisms for doing this has turned out to be the AAMC Education Networks, which make it possible for the membership to identify colleagues interested and expert in six high-priority problem areas. New networks may be developed in clinical evaluation and among those responsible for "Introduction to Clinical Medicine" courses.

One of the most enduring forums for discussing medical education has been the Conference on Research in Medical Education. This year RIME celebrates its 25th Anniversary. A brochure recounting the history of RIME and its contributions to medical education has been prepared. The Silver Anniversary Invited Review emphasizes the importance of drawing from adult education in confronting the challenges of medical education.

The Executive Council appointed an ad hoc committee to review the Association's Medical College Admission Test program. The committee found that the MCAT is useful in helping to establish minimum academic qualifications of applicants. It recommended that the essay pilot project continue to assess the inclusion of an essay as one subtest of the MCAT. The Committee recommended an evaluation of the content of the science subtests and the consideration of alternative methods of score reporting. The Committee also endorsed a program to improve the ways that admissions committees use the MCAT in selection decisions.

The MCAT Essay Pilot Project has yielded some very encouraging results. The project has been successful in developing essay topics that elicit a sufficiently wide range of responses. Correlations between the essay and other MCAT tests indicate that the essay assesses a skill or skills unexamined by the other tests. Data from three administrations verify that essays can be scored with a high degree of reliability. Research on the development of essay topics that are equivalent in different administrations continues.

Validity data on enrolled medical students and the essay's impact on the selection process are being investigated by schools participating in the pilot project. Research on the essay's impact on the attitudes, course selection, curriculum, and application patterns of undergraduate students has been designed. Cost data on the development, administration, and distribution of the essay will become available as the project progresses. The essay will continue to be administered on a pilot basis in 1987. Many schools expect to use essays in their 1988 admissions decisions.

Results from an Association survey of admissions officers will be used to evaluate the present system of disseminating MCAT data and interpretive information and to document methods of using scores in the admissions process. A nontechnical guide to the use of the MCAT will be available November 1986.

Clinical data are being collected from several schools in the MCAT interpretive studies program. These data will be used to examine the relationship between pre-admission data and performance in the clinical setting. Research is underway on the appropriateness of the current format and content coverage of the MCAT. Two studies on the effects of commercial review courses on MCAT scores recently appeared in the *Journal of Medical Education.*

The MCAT Score Release System now allows examinees to have personal data circulated to U.S. and Canadian schools of medicine, osteopathy, podiatry, and veterinary medicine for recruitment purposes. For the spring 1986 administration, 87 percent of the examinees signed the release.

The MCAT continues to be offered in New York State under the protection of the preliminary injunction issued by the Federal Court in 1980 after the Association challenged that state's law on disclosure of standardized tests. Discovery has been under way during this past year and a trial date seems likely in the coming year. Meanwhile, new legislation further regulating standardized testing failed to be enacted but is expected to be reintroduced.

The Association completed work on its project on the evaluation of medical information science in medical education, and more than 5500 copies of the project's final report have been distributed. The report concluded that medical informatics is basic to the understanding and practice of modern medicine, and recommended that it become an integral part of the medical education program. Academic medical centers were urged to develop an identifiable locus of activity in medical informatics to foster research, integrate instruction, and encourage appropriate uses for patient care. The National Library of Medicine was recognized as the major federal agency to support the development of this field.

Biomedical and Behavioral Research

The support and conduct of research in the biomedical and behavioral sciences continue to receive challenges from many quarters.

The scale of the federal investment in biomedical and behavioral research persists as a major concern for the academic medical community. The number of high quality research proposals continues to increase faster than the growth of funding to support such research. This growing disparity between existing scientific opportunities and the resources available to realize this potential generates tremendous pressures and conflicts within the system. These pressures were amplified by the enactment of the Gramm-Rudman-Hollings deficit reduction amendment, which resulted in a 4.3 percent across the board reduction of the funding for biomedical and behavioral research in fiscal 1986.

The Gramm-Rudman-Hollings cuts in funding, coupled with the failure of the Congress to appropriate sufficient funds to pay the full costs for the 6,100 new and competing research projects grants that it mandated the National Institutes of Health to support in fiscal year 1986, necessitated an average "downward negotiation" of more than 9 percent from study section recommended levels for competing grants and 6.5 percent for non-competing grants at the NIH.

The specter of additional Gramm-Rudman-Hollings budget slashing in fiscal year 1987, combined with administration efforts to "zero out" programs such as the Biomedical Research Support Grants, augur further fiscal stringencies that can only aggravate the already intense competition for research funding.

The difficulties in reconciling limited federal resources and the costs of research surfaced in the debate surrounding the administration's attempt to reduce payments for the "indirect" costs associated with federally sponsored research projects. In February, the Office of Management and Budget (OMB) published a proposal to limit the administrative costs portion of the indirect costs to 26 percent of the mean total direct costs (MTDC) as of April 1, 1986, and to 20 percent of MTDC as of April 1, 1987. The 20 percent ceiling is below current cost recovery for all but 10-15 percent of the nation's top 150 research universities.

The Association urged OMB to negotiate with research faculty, university administrators, and other interested parties to reorganize the accounting of indirect costs. AAMC urged that instead of lumping all administrative costs together, OMB provide a fair and reliable method for determining departmental administrative costs that also permits relief from the need for faculty effort reporting and a separate cost pool for those administrative expenses mandated by federal regulation (such as animal care and human subjects committees).

At the same time, the Association advocated imposition of an immediate freeze in place of each university's present administrative rate through fiscal year 1987 and permanent elimination of the DHHS system of retroactive reimbursement of indirect cost adjustments during the grant year. The Association noted that these two actions would distribute budgetary savings more equitably and prevent further growth in administrative indirect cost rates while negotiations took place.

The Government-University-Industry Research Roundtable of the National Academy of Sciences assembled a negotiating team representing the major constituencies to meet with OMB. As a result of pressure from the academic community, the OMB modified its proposal in early June. The revised policy limits the salaries and benefits for administrative work by department heads, directors of divisions and research units, faculty, and professional staff at three percent of MTDC. Expenses for deans' offices, academic departments, organized research units, and other similar units will no longer be included under the general administration cost pool. The departmental administration rate will be based on an accounting of actual departmental administrative indirect costs, with the exception of those now included in the fixed three percent category. No effort reporting documentation will be required to support the three percent allowance. This new proposal will be implemented on all grants awarded after July 1, 1987.

The competition for research support also has resulted in efforts to persuade the Congress to earmark increasingly larger portions of the federal research budget for particular programs. The wisdom of such earmarks was again debated dur-

ing reauthorization hearings for the Small Businenss Innovation Research (SBIR) program. This set-aside program was enacted in 1982, and currently requires the Department of Health and Human Services and other federal agencies with annual extramural research and development budgets in excess of $100 million to reserve 1.25 percent of those budgets for awards to small businesses.

At hearings in July on H.R. 4620, which proposed permanent authority for the SBIR program, the Association opposed the use of set-asides as not compatible with sound public policy. Such mechanisms reduce programmatic flexibility and force federal agencies to support grant applications on a basis other than scientific and technical merit. The AAMC also cautioned against establishing permanent authority for a program that has not undergone any formal evaluation of the effectiveness of its expenditures.

The Association completed a major review of its policies on biomedical and behavioral research with the publication, in April, of the final report of the ad hoc Committee on Federal Research Policy. This committee conducted a year-long overview of the broad policy issues related to the federal role in biomedical and behavioral sciences research. This overview was stimulated, in part, by the activities of the House Task Force on Science Policy, which moved into its second year of a study of all aspects of national science policy.

The committee made recommendations in six key areas related to biomedical and behavioral sciences research: the goals of the federal research effort; research manpower and training; research infrastructure; research awards system; federal funding for research; and formulation of federal science policy.

The committee reaffirmed that the goal of federally supported biomedical and behavioral sciences research should be to acquire an expanded base of scientific knowledge to improve the health of the American people. It was noted that NIH and ADAMHA have the acquisition of basic biological and clinical knowledge as their primary mission, and that this mission must be protected and enhanced. The limited resources available for research must not be deployed to achieve non-scientific objectives. The committee concluded that the benefit to all aspects of the economy derived from research should be a consequence, not a goal of the research effort.

The federal contribution to biomedical and behavioral research through NIH and ADAMHA is unique because it emphasizes basic biological and clinical investigations, many of which would go unfunded without federal support. The committee emphasized the long-term nature of biomedical research; the nation's medical schools and academic medical centers took years to acquire and develop the talent and resources necessary to achieve current levels of contributions to knowledge. Reductions in federal support for biomedical research have a far greater impact than merely the immediate cuts suffered by individual programs; such cuts have a lasting effect on the nation's biomedical research effort that may take years to reverse.

The committee recommended an increase of ten percent per year in annual appropriations for NIH and ADAMHA to maintain the present scale of research effort. An additional five to ten percent yearly increase in NIH and ADAMHA appropriations for the next five years was recommended to allow the system to take full advantage of currently available but unmet scientific opportunities.

The committee urged that the federal government continue to maintain diverse programs of research support that emphasize the vital role of investigator-initiated research. The committee also reaffirmed the value and necessity of basing funding selections on a rigorous technical review for scientific merit. They advocated continuation of the predominantly extramural and academically based system of research to take advantage of the enormous national pool of creative scientific talent and resources, and to maintain the unique bond that exists between education and research. In addition, a diversity of institutions provides greater flexibility to respond to scientific opportunities of varying degrees of scale and complexity.

The basic components of a sound federal program for the support of research training are in place. The committee recommended maintaining the current heterogeneity of training programs, with continued emphasis on support for postdoctoral programs. Two problem areas with regard to research training were highlighted. The committee recommended efforts to identify and address the causes for the declining interest of young people in careers in biomedical research. The committee also expressed concern over the lack of well-qualified physician investigators and praised programs such as the NIH Medical Scientist Training Program and the Physician Scientist Awards as models for the design of M.D. research training.

Often overlooked in the debate surrounding the scale of the federal investment in biomedical research are the research resources beyond the di-

rect cost portion of the grant that are needed to sustain the fragile research environment. The committee made several suggestions to enhance federal support for equipment, facilities, and shared resources. The committee also urged all segments of the research community to work toward ensuring that indirect costs are true and necessary costs of research. At the same time, the government must make efforts to streamline and reduce the bureaucratic requirements that add unnecessary institutional and administrative burdens and indirect costs.

Finally, the committee urged greater involvement of the scientific community in the formulation of national research policy by the executive and legislative branches. Efforts must be made to ensure that the Congress and the president receive impartial, realistic, and timely advice from scientists related to the goals of the biomedical and behavioral research and the means to achieve these goals. Research agency advisory councils and the National Academy of Sciences were seen as appropriate sources of such advice.

Attention remains focused on the issues surrounding the care and use of animals in laboratory research. In October 1985, a combined ad hoc committee representing the AAMC and the Association of American Universities issued its final report on the "Governance and Management of Institutional Animal Resources." This report identifies the responsibilities of institutional personnel in assuring that all animal facilities and research and training procedures are beyond reproach and are in compliance with all applicable laws, regulations, and guidelines. The report also addresses the need to educate the non-scientific public about the importance of animals in research and education. The report's recommendations are intended as guidelines for institutional administrators, animal resource managers, researchers, faculty and public affairs personnel.

In December the president signed legislation amending the Animal Welfare Act governing the use of animals in research, education, and testing. In a coordinated effort, the Association joined forces with other members of the biomedical research community to assure that the needs of researchers were considered during the lengthy negotiations involved in the final passage of this bill. As a result, the amendments to the Animal Welfare Act are far less burdensome and restrictive than early legislative proposals, and should ensure continued access to animal models for both research and education in the biomedical and behavioral sciences. The Association was also active in providing information to the Department of Agriculture's Animal and Plant Health Inspection Service (APHIS), which was responsible for promulgating regulations to implement the Animal Welfare Act amendments. The Association was concerned that APHIS recognize the need for broad, generic regulations that will allow for institutional flexibility and individual professional judgment.

The Association also joined nearly 100 other organizations representing both scientific and animal protection interests in urging increased funding for APHIS. The administration had proposed that APHIS be terminated, in spite of the new responsibilities mandated by the Animal Welfare Act amendments. The Association urged the Congress to provide $6.6 million for APHIS in fiscal year 1987.

Activities on behalf of animal rights continue. Beginning in April, animal rights groups, led by the People for the Ethical Treatment of Animals, staged a vigil at the NIH campus, demanding the release of 15 primates being held at the NIH animal facility. The animal activists wanted the animals, which were owned by the Institute for Behavioral Research, to be transferred to a privately-owned primate facility in Texas. The vigil attracted the attention of more than 200 congressmen and 50 senators who signed letters to the Director of NIH requesting the release of the animals to the Texas facility. The Association and 27 other organizations sent a letter to Congress in support of the NIH position that the monkeys were the subject of pending litigation and that the animals should be available for an appropriate institution to complete the research for which they were acquired. Resolutions were introduced in both the House and Senate requiring that NIH transfer the animals to the private facility, but these measures did not receive sufficient support. The Department of Health and Human Services and NIH attempted to reach a compromise late in July by sending the primates to the Delta Primate Center in Louisiana, where the animals would not be subjects of invasive research procedures and every reasonable effort would be made to re-socialize them.

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, collects and maintains 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 to be used in completing questionnaires for other organizations, identifying alumni serving on faculties at other schools, and producing special reports. As of June 1986, the Faculty Roster data base contained records for 58,277 active and 60,924 former members of medical school faculties.

A survey of all full-time faculty in departments of medicine was recently conducted in cooperation with the Association of Professors of Medicine. Results of this study were 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 research activities of more than 7,000 faculty members.

Faculty Roster data are periodically matched to NIH records on research training and grant applications and awards to analyze the relationships among training, academic careers, and the faculty's role in the conduct of biomedical research. These research activities, as well as the maintenance of the Faculty Roster database, receive support from the National Institutes of Health.

A new edition of *Women and Minorities on U.S. Medical School Faculties* was published in early 1986. This is an updated and expanded version of reports that have been published periodically since 1976. The Association assists its members in their affirmative action recruitment efforts by providing, on request, lists of women and minority faculty members who are qualified for specified faculty openings and who have consented to the release of their names. Since 1980 more than 1,200 recruitment requests from medical schools have been answered.

The Association's *1985–86 Report on Medical School Faculty Salaries* summarizes compensation data provided by 122 U.S. medical schools. The tables present mean compensation data 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 36,150 full-time faculty reported to the survey.

Students

As of September 5, 1986, 31,267 applicants had filed 293,206 applications for the entering class of 1986 in the 127 U.S. medical schools. These totals, although not final, represent a continuing decrease in the national applicant pool. The 1986 applicant pool is estimated to be approximately 31,300 applicants, a 4.8 percent decrease from 1985.

The total number of new entrants to the first year medical school class decreased from 16,395 in 1984 to 16,268 in 1985. Total medical school enrollment also declined from 67,016 to 66,585.

The number of women new entrants reached 5,520; the total number of women enrolled was 21,650, a 1.6 percent increase. Women held 32.5 percent of the places in the nation's medical schools in 1985 compared to 26.5 percent in 1980.

There were 1,388 underrepresented minority new entrants, 8.5 percent of the 1985 first year new entrants. The total number of underrepresented minorities was 5,655 or 8.5 percent of all medical students enrolled in 1985.

For the 1986-87 first-year class, 836 applicants were accepted under the Early Decision Program by the 75 medical schools offering this option. Since each of these applicants filed only one application rather than the average 9.3 applications, the processing of approximately 6,900 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.

American Medical College Application Service in processing first-year application materials for the 1986 entering classes had 102 medical schools participate, as well as the Drew/UCLA and Berkeley/San Francisco Joint Medical Programs. In 1987, 105 medical schools will participate in AMCAS. In addition to collecting and coordinating admission data in a uniform format, AMCAS provides rosters and statistical reports and maintains a national data bank for research projects on admission, matriculation and enrollment. The AMCAS program is guided in the development of its procedures and policies by the Group on Student Affairs Steering Committee.

The AAMC Advisor Information Service circulates rosters and summaries of applicants and acceptance data to 340 subscribing health professions advisors at undergraduate colleges and universities.

The Medical Sciences Knowledge Profile examination was administered for the seventh time in June 1986 to 1,659 citizens or permanent resident aliens of the United States and Canada. The examination assists constituent schools of the AAMC in evaluating individuals for advanced placement. While 3.9 percent of those registering for the test had degrees in other health professions, 91 percent were enrolled in a foreign medical school.

Beginning in 1983, the AAMC and the National Resident Matching Program cooperated to establish the AAMC/NRMP Follow-up System for medical school graduates. This system combined the results of the matching program with the AAMC Student Records System and provided listings to individual medical schools of their current graduates as well as prior year graduates and Fifth Pathway students registering for the current match. These listings provide information on programs and hospitals where these individuals matched through NRMP and solicit information on those who did not register for the match, withdrew from the match, or registered but did not receive a residency assignment through NRMP. This exchange of information by U.S. medical schools has continued for three years. Commencing with the 1985 graduating class, actual LCME medical school graduate reports were generated from the follow-up system for the schools to report graduation information to the AMA and the AAMC.

In the fall 1984, hospitals identified in the 1983 follow-up system as having individuals enrolled in their graduate medical education programs received computer-generated listings to confirm the previous year's appointment and to report individual plans for the current academic year. They were also asked to provide similar information for individuals who did not appear on the computer-generated listings. Responses were received from all 825 hospitals surveyed. This was repeated in fall 1985 with the addition of 1984 medical school graduates and associated match results, and will be continued for 1986.

During the past year, the Association has worked with student affairs offices in the devel-

opment of guidelines for the management of students with Acquired Immune Deficiency Syndrome. A document containing examples of institutional policies has been distributed and an updated version will be disseminated in early 1987.

The Association has conducted several studies to examine the characteristics of the applicant pool particularly during the period beginning in 1981. Although the number of applicants has decreased to a national applicant-to-position ratio of 1.9 to 1, the qualifications of the group as assessed by MCAT scores and GPAs have not been affected. While the national group of 1985 applicants is comparable to the 1981 group, there exists considerable variation in the qualifications of the applicant group categorized by age, sex, and self-description. These differences are the subject of current study by the Association.

The increasing cost of medical education and the rise in the debt of medical school graduates are of great concern to the Association. The percentage of graduates with debt in excess of $30,000 has increased from 14.5 percent in 1981 to 38.6 percent in 1985. In 1985, the mean debt for graduates with debt was $30,256.

In response to the substantial changes in student financial assistance, the Association has initiated MEDLOANS, a new consolidated medical student loan program, in which students can apply for three federal loan programs (GSL, ALAS, HEAL) and a new Alternative Loan Program (ALP) through a consolidated application procedure. ALP is an assured access program that does not require the medical student to have a cosigner, nor does it require the borrower to make interest payments while in school or during the first 3 years of residency training. Since it is not a federal loan, the terms and conditions are not subject to the unpredictable changes made by Congress. The Association is also planning a comprehensive program in counseling and debt management for medical students that will begin in spring 1987.

The Association continues to administer several projects to enhance opportunities for minorities in medical education. The activities under two Health Career Opportunity Program grants include 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.

The Association, through the continuing support of the Robert Wood Johnson Foundation, is developing the third edition of *Minority Students in Medical Education: Facts and Figures.*

Recently, the AAMC was awarded a contract from the Department of Health and Human Services, Health Resources and Services Administration to provide an analysis of medical schools with high and low minority graduation rates. The study will examine the factors associated with the retention and graduation of underrepresented minorities. The outcome of this project should be of considerable value to understanding the factors that influence minority student enrollment in and graduation from non-minority institutions.

Institutional Development

The AAMC Management Education Programs, now in their 15th 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 presented to 105 medical school department chairmen and assistant and associate deans from 72 institutions. 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.

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 51 individuals from 29 institutions. The seminar acquaints administrators with 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.

A series of four educational seminars devoted to the challenges posed to academic medical centers by alternative medical care delivery systems was held regionally during the spring of 1986. Each included an analysis of the current environment, a conceptual framework for analyzing the academic medical center's 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.

Six new workshops based on AAMC data and conclusions from its clinical evaluation project are designed to assist schools in the development and implementation of more responsive evaluation systems.

A key strategic issue for AAMC member institutions is the preservation of their patient bases for teaching and research in a more competitive medical practice environment. The AAMC Committee on Faculty Practice at its first meeting discussed the growth of service organizations associated with the medical education institutions and increasing institutional dependence on medical practice income, academic medical center sponsorship of and/or affiliation with health maintenance organizations, the governance of faculty practice activities, trends toward ambulatory care delivery and role of the academic medical center in providing primary care, and clinical faculty appointment systems and personnel policies. In addition to the regional seminars on alternative delivery systems, several initiatives have resulted from the committee's activities. A survey identifying medical schools with special non-tenure clinician-educator faculty tracks for full-time faculty members engaged in patient care and teaching was reported. The Association is seeking funding for a more comprehensive study of the appointment systems and personnel policies that govern the activities of clinical faculty members, physician employees of the medical center, and medical staff. That study includes a national conference on faculty practice in 1987. In November 1986, the AAMC will sponsor a small group invitational symposium on adapting clinical education to the ambulatory care setting.

Teaching Hospitals

The refinement of the Prospective Payment System (PPS) for Medicare reimbursement to hospitals and the options for future financing of graduate medical education continue to be important concerns for the AAMC. The Association is also concerned with the effect of the prospective payment system on quality of care, how capital will be handled under PPS, continued access of non-profit hospitals and universities to tax-exempt financing, and proposed changes to Medicare reimbursement for financing graduate medical education.

AAMC actions were taken within the framework of two policy documents accepted by the Executive Council on Medicare reimbursement and on financing graduate medical education.

As a result of activities in the last Congress, the Association reviewed and revised its positions on Medicare hospital payment policies. The AAMC vigorously opposes any freeze in Medicare payments to hospitals and strongly recommends that Congress amend the prospective payment system so that payments are made on a DRG-specific, blended rate of hospital-specific and federal component prices. If Congress does not enact DRG-specific price blending, then the Association recommends amending the DRG price formula to a blend of 50 percent hospital-specific costs and 50 percent regional average costs.

The AAMC supports recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and a regression equation which incorporates only variables used in determining DRG payments. The most recent analyses by the Congressional Budget Office support a curvilinear adjustment of 8.7 percent per 0.1 resident per bed. The AAMC strongly supports including the same types of residents in the payout of the indirect medical education adjustment as are included in the statistical formulation of the adjustment. The AAMC supports eliminating Medicare funding for residents who are not graduates of accredited medical or osteopathic schools in the United States or Canada. Explicit Medicare funding should be retained for graduate medical education for the period required to attain board eligibility (to a maximum of five years) plus one additional clinical year for advanced specialty and subspecialty positions in hospitals in which the positions were supported by Medicare in FY1984-85. For any resident presently in training who would not be included in the passthrough, there should be a phase-in of Medicare payment changes.

The Association endorses an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent Medicare patients, even if implementation of such an adjustment leads to a recalculation of the indirect medical education adjustment. The AAMC supports correcting the wage index numbers used in prospective payments but recommends amending the law to eliminate the current requirement that the new index numbers be applied retroactively to October 1, 1983. Congress should require HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment. The Association also advocates removing the Medicare Part A Trust Fund from the automatic reduction provisions of the Emergency Deficit Control Act of 1985.

The AAMC Committee on Financing Graduate Medical Education was charged with assessing the current methods for financing graduate medical education and determining whether those sources could continue to provide adequate support in the near future. Since graduate medical education takes place primarily in teaching hospitals and adds to the cost of operating the hospital, changes in payment methods have raised the concern that teaching hospitals may no longer be able to sustain their current support of graduate medical education. Further, more care is delivered in ambulatory settings which have no clear sources of funding for education activities.

The first major issue discussed by the Committee was the creation of a separate fund for financing graduate medical education to eliminate the current reliance on teaching hospital payments from insurers and governmental programs. However, it would mean total dependence on the funding policies established by this single source. The committee concluded that changes in hospital payments are likely to reduce the support teaching hospitals can provide for graduate medical education. Although the full effects of the current environment on teaching hospitals' ability to sup-

port graduate medical education are unknown, the committee believed that they do not warrant acceptance of the disadvantages of a single national fund. The committee recommended that teaching hospital revenues from patient care payers continue to be the principal means of supporting graduate medical education with all payers providing their appropriate share. Sources such as state and local governments, special purpose federal programs, and private organizations may also need to provide greater support in the future. Other recommendations of the committee concerned the obligation of the medical education community to monitor the quality of residency training programs, to train the types of physicians needed by society, and to operate in a cost-effective manner. The committee further recommended that limits be placed on the length of training for which teaching hospitals are expected to provide a major source of support. Residents should be supported in their training at least until they are capable of the independent practice of medicine. A coordinated, nationwide private sector effort should be made to collect and disseminate information on the supply of physicians by specialty, and residents and programs in the ambulatory care settings must be supported.

In February 1986, the AAMC testified before the Subcommittee on Health of the House Committee on Ways and Means on Medicare payments for hospital capital. The AAMC testimony pointed out that historical data comparing capital to total expenses have been misinterpreted by some to imply that major teaching hospitals have lower absolute capital costs than other hospitals. In fact, capital costs per unit of workload performed are higher in major teaching hospitals than in other hospitals. Further, major teaching hospitals have older plants than other hospitals, and recently increased capital spending by major teaching hospitals may alter statistical relationships from the 1970s and early 1980s. The AAMC supports replacing institutionally specific, cost-based retrospective payments for capital with prospectively specified capital payments, and supports separating capital costs into movable equipment and fixed equipment and plant. The Association's testimony indicated support for incorporating capital payments for movable equipment into prospective payment using a percentage "add-on" to per case payments. The AAMC supports a percentage add-on to per case prices for capital costs of fixed equipment and plant that is no less than Medicare's current percentage of hospital payments for facilities and fixed equipment, provided it appropriately compensates teaching hospitals for their distinctive costs. The AAMC further supports a long-term, hospital-specific transition from the capital passthrough to prospective payments for plant and fixed equipment. The transition period should allow each hospital its choice of cost reimbursement for depreciation and interest on adjusted base period capital or a prospective percentage add-on that is no less than Medicare's current percentage of hospital payments for facilities and equipment.

The Association testified before the House Ways and Means Committee's Subcommittee on Health outlining the AAMC's positions on the Administration's FY1986 Medicare budget proposals. Of specific concern to teaching hospitals and physicians were proposals to: reduce payments in direct medical education; reduce to 5.79 percent the indirect medical education adjustment in spite of an extensive CBO analysis supporting a reduction to only 8.7 percent; implement DRG payments at 100 percent national rates effective October 1, 1987; increase DRG prices by two percent, essentially a freeze at 1985 payment levels if Gramm-Rudman-Hollings reductions go into effect; implement a restrictive capital payment policy; and retroactively recalculate the Medicare economic index to reduce fee payments for physicians.

The AAMC made a number of specific recommendations in its testimony. First, the Association supported retaining explicit Medicare funding of graduate medical education for at least the number of years required to attain board eligibility in various specialties (to a maximum of five years) plus one additional clinical year where hospitals had supported the position in FY84-85. Other AAMC recommended changes in training support were congruent with positions taken by the Executive Council. The testimony also recommended that Congress amend the prospective payment system so that payments are based on a DRG-specific, blended rate of hospital-specific and federal component prices, that the current pause in the phase-in of national prices be continued throughout 1986, and that the FY1987 price be based on a hospital-specific component of at least 25 percent. The AAMC further supported increasing DRG prices for 1987 by the market basket plus 0.25 percent, and establishing an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent patients. The AAMC opposed any extension of the Medicare freeze on payments to physicians for professional medical services, and urged Congress to mandate retaining the present methodology for

calculating the medical economic index.

In March 1986 the AAMC testified before the Subcommittee on Health of the Senate Finance Committee on Medicare payments for hospital capital. The administration's proposed budget for FY1987 advocated implementing a new policy for Medicare capital payments by regulation. The AAMC strongly opposed changing Medicare capital payments by regulation, preferring the legislative process because it is more open and public. To ensure that the legislative process has an opportunity to consider a new capital payment policy, the AAMC recommended that the Health Subcommittee adopt legislation prohibiting HHS from making changes in the capital passthrough until Congress enacts legislation with a specific capital payment methodology. The Association further recommended that the federal component for computing capital payments for a phase-in be based on actual 1986 Medicare capital payments updated annually for increased construction and borrowing costs, and that the hospital-specific component for computing capital for a phase-in transition be based on each hospital's actual capital costs for that current year. With regard to the capital proposal made by Senators Durenberger and Quayle, the AAMC recommended consideration of a hospital-specific transition approach which varies the transition period with either the percentage of a hospital's fixed assets which are debt financed or the percentage of fixed assets presently depreciated. The Association recommended specifying the base year and the specific update factors in the legislation, recommended that any offset of interest earned be limited to interest earned on funded depreciation, and that any effective date for a new capital policy be based on individual hospital fiscal years.

The AAMC joined twenty-nine other organizations representing nonprofit health care and higher education institutions in opposing House Ways and Means Committee action to restrict tax-exempt financing for 501 (c) (3) organizations. The committee placed section 501 (c) (3) bonds under a state volume cap and protected only about one-half of their 1984 volume with a $25 per capita set-aside. This set-aside would inevitably become a "ceiling" rather than a "floor" because the demand for other types of bonds far exceeds the amount which could be issued under the remainder of the volume cap. The AAMC and other organizations opposed the committee's position because it did not recognize that private nonprofit health care and higher education institutions serve public purposes which the government would otherwise have to provide. It would treat private nonprofit institutions differently from public institutions performing the same functions. The committee's position would arbitrarily allocate capital for nonprofit hospitals and universities according only to state population, despite these institutions' characteristics as national resources.

The committee bill also denied advance refunding authority to section 501 (c) (3) organizations, which is used to reduce debt service. The committee also proposed a limit on the amount of outstanding bonds of institutions other than hospitals, eliminated the use of arbitrage, and placed numerous restrictions on bond issuance for section 501 (c) (3) organizations. The AAMC emphasized that it is essential that they not be subject to any volume restrictions, and that such organizations have the same limited advance refunding authority that the bill provides for governmental bonds.

Another issue of concern to the AAMC in the past year has been Medicare payment for physician services. The AAMC recognizes the present dissatisfaction and unrest with Medicare's usual, customary and prevailing system for detemining payments for physician services, but stresses that the form and content of any revised payment system for professional services will provide economic incentives that influence the attractiveness of the various specialties and subspecialties. Therefore, change in the payment system must be approached carefully and with demonstration projects so that intended benefits and unintended consequences are understood. At the same time, the AAMC believes that Congress should not extend the physician fee freeze. Currently, fees for physician services are based on information submitted in 1982 with no adjustment provided for increasing practice costs such as the rapid rise in malpractice premiums. The AAMC strongly recommends halting the fee freeze on physician services.

As new approaches to physician payment are considered, the AAMC urges careful attention to the application of the approach in teaching settings. The revised payment system should incorporate several principles for the equitable application of payments in teaching settings. If the level of professional medical services provided is equivalent to the level of services furnished a patient in a non-teaching setting, payment should be made on the same basis. Payments should be determined in the same manner regardless of setting. The determination of the level of payments for professional services should not be influenced by the extent to which physicians provide services to

non-paying or Medicaid patients. Payments for physicians in teaching settings should not impose requirements which result in artificial or atypical relationships on the provider organization and its medical staff. The AAMC further believes that special attention should be given to ensuring that any revised payment system does not preclude or discourage resident training in the full spectrum of long-term care and ambulatory care settings.

The Association expressed its views on the proposed regulation to augment the procedures for establishing reasonable charge limits for Part B of Medicare in a letter to the Health Care Financing Administration. The proposed regulation sought to establish a mechanism by which the usual method of establishing a "reasonable charge" for a service can be abridged when it will result in an unreasonably high charge. The AAMC expressed its understanding that there may be instances in which HCFA's formula for determining charges may result in inappropriate levels of payment; e.g., new medical technologies and techniques can dramatically affect the time and effort involved in providing services to patients. However, the Association opposed the method suggested in the proposed regulation, in which HCFA would identify areas in which it suspects that Part B compensation is excessive, would calculate new payment amounts for these services, and would publish proposed regulations to establish those payment amounts. After eliciting comments from the public, HCFA would then publish the final regulation, which may contain changes from the proposed rule. As the agency responsible for Medicare outlays, HCFA is not an objective independent party able to determine what constitutes a "reasonable" outlay for a particular service. Under this regulation, HCFA would act as both the unilateral determiner of the rules for "reasonable payment" under Part B and as the payer. The interests of the government, patients, and providers would be best served if proposed changes from the current accepted method of fee determination were discussed publicly, and enacted only on advice and consent of a knowledgeable, independent advisory body established to look at such payment issues. The Physician Payment Review Commission (PhysPRC) or a similar body would be an appropriate adviser for these payment changes. The Association proposed an alternative process in which HCFA publishes instances which it believes warrants deviation from the normal methodology for calculating payments. That publication is followed by a hearing before an independent body which reviews HCFA's rationale and which advises HCFA on whether to proceed with regulations.

In March 1986 concern about health budget cuts prompted the AAMC to join with over one hundred health-related organizations in writing to Senator Pete V. Domenici, chairman of the Senate Budget Committee. The letter stated that despite concerns about budget deficits, a balanced solution is needed. The organizations were deeply disturbed by continued efforts to cut public health programs, including health research and education, in a disproportionate manner. The letter pointed out that during the past five years, Medicare had been cut by nearly $40 billion. This constituted 12 percent of total budget cuts, even though Medicare represented only 7 percent of federal outlays. An additional $55 billion in cuts over the next five years were proposed along with cuts of $1.3 billion from Medicaid in 1987, although that program is already unable to protect millions of indigent patients due to inadequate funding. These proposals would adversely impact the quality of services and access to needed health care by elderly and poor patients. The AAMC urged Congress to adopt a budget resolution which rejected such arbitrary and unfair cuts and established reasonable targets for health programs in the FY1987 budget resolution.

In June 1986 the Association wrote all members of Congress opposing the tax bill amendment being offered by Senator Gordon J. Humphrey. Senator Humphrey wished to amend the tax reform bill by denying tax-exempt status and tax deductibility to any organization that "directly or indirectly performs, finances, or provides facilities for any abortion" except when required to save the life of the mother. This amendment would jeopardize the tax-exempt status and charitable contributions for most of this nation's major teaching hospitals and for several major private universities which own a teaching hospital. It is inappropriate to deny tax-exempt status to these multi-function, public purpose organizations simply because they offer a medical service that is legal and desired by their patients. Although this amendment was subsequently removed from the tax reform measure, its supporters plan to introduce it as an amendment to another important piece of legislation.

The AAMC has submitted written comments to the Health Care Financing Administration regarding the proposed rule for the fourth year of the Medicare prospective payment system. The Association is especially interested in the proposed rules because its teaching hospital members provide approximately 20 percent of Medicare inpatient days. The Association's comments

focused on the increase in DRG prices, payment for capital costs, market basket recalculation, restandardization of prices, classification of burn patients, and periodic interim payments. In the proposed rule, HCFA argued that an appropriate price increase for FY 1986 DRG prices is a 0.9 percent decrease, but recommended a 0.5 percent increase in DRG prices. The AAMC is concerned with the inadequate justification HCFA offers for both the increase and the decrease. Given HCFA's apparent unwillingness to develop an adequate, politically independent estimate for DRG prices, the AAMC recommends using the price increase of 2.2 percent developed by the Prospective Payment Assessment Commission (ProPAC).

The proposed regulation also recommended including capital payments in DRG prices by regulation, and the AAMC reiterated its support for House and Senate efforts to preclude a regulatory change in capital. The AAMC strongly recommends that HCFA continue to pay capital costs using the current cost reimbursement methods until Congress provides an alternative capital methodology.

The AAMC opposes five major elements of HCFA's capital proposal. First, the capital cost data from 1983 substantially understate current capital costs. HCFA's efforts to update 1983 data are inadequate because the HCFA adjustment is based primarily on interest rate changes and ignores the increase in capital spending since 1983. Second, the AAMC opposes using a four-year transition to national rates as too short to allow hospitals with major modernization or replacement projects to adjust their capital costs to an average national rate. A ten year transition is more appropriate. Third, the AAMC opposes limiting the hospital-specific payment during the transition to 1986 allowable costs. During each year of the transition, hospitals should be allowed to use actual allowable costs. Fourth, the AAMC opposes offsetting interest received on funded depreciation against interest paid on capital costs. For twenty years, allowable capital costs have not included the offset, and debt instruments currently in force often require segregating both depreciation and interest earned on funded depreciation. Thus, interest earned on funded depreciation is often not legally available for capital payments. Fifth, the AAMC opposes a capital exceptions policy that requires hospitals to approach insolvency before qualifying for more individualized capital payments. In good faith, communities and hospitals have sought to maintain technically up-to-date facilities and equipment. Requiring these hospitals to substantially weaken their financial position in order to have atypical costs recognized is an inappropriate public policy which threatens hospital viability and beneficiary access. Each of these five elements of the capital proposal is a major shortcoming; together they constitute an unacceptable proposal.

In developing a capital payment policy, the AAMC does not recommend using a separate component after the transition period. To accomplish this objective, it is important to adjust all payments by the case mix index, the indirect medical education adjustment, and the disproportionate share adjustment. To help ensure equity across hospitals, it is necessary to standardize any capital component by each of these payment variables.

The AAMC supports the regular revisions in the market basket to estimate price increases in the goods and services purchased by hospitals. The AAMC is disappointed, however, that HCFA, in proposing a new wage index, has not conducted a retrospective impact analysis using data from 1982-1984. The AAMC believes that in proposing a new market basket, HCFA should demonstrate the redistributional impact of using the new approach. Until such an analysis is conducted and published, the AAMC is unable to evaluate the market basket weights and proxies of the HCFA proposal.

COBRA made significant changes in area wage indices, the indirect medical education adjustment and the disproportionate share adjustment. As a result, the law required HCFA to restandardize regional and national prices. The AAMC believes these adjustments have been proper.

The AAMC is pleased that HCFA is using its discretionary authority to categorize and weight tertiary care services. While HCFA has not released the data necessary to evaluate the change in DRGs relating to burn patients, the Association believes this is an appropriate step and recommends that HCFA continue to develop additional diagnosis-related groups for patients requiring substantially different hospital resources.

The AAMC opposes HCFA's proposal simply to eliminate the periodic interim payments until detailed specifications for intermediary performance are in place and enforceable. Rather than abandoning PIP in a blanket manner, HCFA should initially establish intermediary standards for paying provider claims. Only when a provider demonstrates a sustained ability to meet the performance standard should HCFA consider eliminating PIP for that intermediary. If an

intermediary is allowed to discontinue PIP, HCFA should publish semiannual data on intermediary payment performance. If an intermediary fails to meet the performance criteria, HCFA should immediately reinstate PIP until the performance standard can be met.

The AAMC believes that the proposed regulation for the fourth year of prospective payment demonstrates HCFA's continued emphasis on limiting program expenditures and its unwillingness to provide adequate public statistical information on the impacts of its proposals.

Another area of concern to the AAMC in recent months has been that developing state and national policies on health care delivery and payments usually assume that teaching hospitals are relatively homogenous. A number of pilot studies conducted by the Task Force on Academic Medical Centers of the Commonwealth Fund clearly indicated that this simplifying assumption is incorrect. In an effort to replace the assumption of homogeneity with clear analytical information on the differing characteristics of subgroups of teaching hospitals, the AAMC has received funding from the Commonwealth Fund for a three-year effort to establish a coordinated database on teaching hospitals. Data will be developed at the individual hospital level so that the impacts of a particular policy can be assessed on different types of teaching hospitals. To the degree that it is possible, the database will be assembled using existing data currently collected by the American Hospital Association, the Health Care Financing Administration, the National Institutes of Health, the Accreditation Council for Graduate Medical Education, and the Social Security Administration. For COTH hospitals, the general data will be supplemented by both existing annual surveys on resident stipends and funding sources for graduate medical education, and by special purpose surveys developed to collect information on issues such as hospital debt structure and payment requirements.

Three types of project reports will be prepared. The first set will develop alternative typologies of teaching hospitals based on their organizational, patient service, educational, research, and financial characteristics. The next reports will use the developed typologies to assess the comparative impacts of existing policies/developments on subgroups of teaching hospitals. For example, changes in the number of admissions can be compared across hospital subgroups to identify relationships between hospital characteristics and operational experience. The third set of reports will use the alternative typologies and the assessments of present policies to model the impact of proposed policies. Advising the AAMC on the project will be a committee comprised of individuals knowledgeable about teaching hospitals and policy analysis.

Communications

The Association continues to wage an aggressive public relations program by encouraging national and regional news media representatives to view the AAMC as a major source of information on medical education, biomedical research and patient care policy and funding issues. More than 25 reporters contact the Association each week to seek interviews and data as they develop their reports for radio, television, newspapers and magazines. The AAMC also generates stories by issuing news releases and conducting news conferences on timely subjects.

The Association's flagship publication is the *President's Weekly Activities Report.* This publication, now in its 16th year, circulates to more than 6,000 individuals 43 times a year. It reports on AAMC activities and federal actions having a direct affect on medical education, biomedical research and patient care.

The *Journal of Medical Education* published 75 regular articles, 59 communications, and 7 briefs, as well as editorials, datagrams, book reviews, letters to the editor, and bibliographies provided by the National Library of Medicine.

Supplements were published on the 1985 AAMC Annual Meeting and Annual Report, commentary on the GPEP report, and the evaluation of medical information science in medical education.

Manuscripts submitted to the *Journal* in 1985-86 totaled 425, compared with 403 the previous year. Of these 425 articles, 136 were accepted for publication, 238 were rejected, 15 were withdrawn and 36 were pending as the year ended. The *Journal's* monthly circulation continued to average about 6,100.

About 20,000 copies of the annual *Medical School Admission Requirements,* 5,000 copies of the *AAMC Directory of American Medical Education,* and 5,000 copies of the *AAMC Curriculum Directory* were published. Numerous other publications, such as directories, reports, papers, studies and proceedings, were produced by the AAMC. Newsletters include the *COTH Report,* which has a monthly circulation of about 2,600; the *OSR Report,* which is circulated twice a year to medical students and deans and *STAR* (Student Affairs Reporter), which is printed four times a year and has a circulation of 1,100.

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 Association meets the needs of its membership and staff through the use of over one hundred terminals and enhanced data communication technology. 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.

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 data to support the admissions process and statistics describing their own and the nation's applicant pool.

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 residency match carried out by the National Resident Matching Program (NRMP), the AAMC and the NRMP receive information on unmatched participants and eligible students who did not enroll. Using this information and the match results, the Association produces lists of graduates with residency choices for each school and for the Liaison Committee on Medical Education. In a continuation of the tracking studies initiated by NRMP, AAMC and NRMP collect data from hospitals and training programs each year, providing data for longitudinal studies extending through residency.

The Student and Applicant Information Management System (SAIMS) consolidates into one comprehensive database more than a decade's information on applicants, medical students, and residents. This is the Association's largest data base, containing information on more than 500,000 individuals. SAIMS provides data for a wide variety of reports, including cross-sectional and longitudinal studies performed by Association staff for researchers at member institutions.

Through a cooperative network at each medical school, the Association updates the Faculty Roster System's information on full-time faculty and periodically provides schools with an organized, systematic profile of their faculty. A survey of medical school faculty salaries is published annually, and the data can be used on a confidential, aggregated basis for special studies requested by member institutions.

The Association maintains an on-line repository of information on medical schools, of which the Institutional Profile System is the major component. IPS contains over 30,000 data items describing medical schools from the 1960s to the present. It is constructed both from survey results sent directly from the medical schools and from other AAMC information systems. The information reported on Part I of the Liaison Committee on Medical Education annual questionnaire is used with the Institutional Profile System to produce the report of medical school finances published annually in 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, 1986, and reviewed in detail the audited statements and the audit report for the fiscal year ending June 30, 1986. Meeting with the committee were representatives of Ernst & Whinney, the Association's auditors, and Association staff. On September 11, the Executive Council reviewed and accepted the final unqualified audit report.

Income for the year totaled $13,068,967. Of that amount, $12,407,342 (94.9%) originated from general fund sources, $159,032 (1.2%) from foundation grants, and $502,593 (3.9%) from federal government grants and contracts.

Expenses for the year totaled $11,891,798 of which $11,226,119 (94.4%) was chargeable to the continuing activities of the Association, $163,086 (1.4%) to foundation grants, and $502,593 (4.2%) to federal government grants and contracts. Balances in funds restricted by grantors increased $45,133 to $383,319. After making provisions for Executive Council designated reserves for special programs in the amount of $223,834, unrestricted funds available for general purposes increased $506,725 to $11,488,124, 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, 1986

ASSETS

Cash		$ 68,206
Investments		19,289,247
Accounts Receivable		535,394
Deposits and Prepaid Items		94,348
Equipment (Net of Depreciation)		935,472
Land and Building (Net of Depreciation)		814,405
TOTAL ASSETS		$21,737,072

LIABILITIES AND FUND BALANCES

Liabilities		
Accounts Payable		$ 1,572,789
Deferred Income		2,040,414
Fund Balances		
Funds Restricted by Grantor for Special Purposes		383,319
General Funds		
Funds Restricted for Plant Investment	$ 496,856	
Funds Restricted by Executive Council for Special Purposes	4,005,693	
Investment in Property and Equipment	1,749,877	
General Purposes Fund	11,488,124	17,740,550
TOTAL LIABILITIES AND FUND BALANCES		$21,737,072

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
OPERATING STATEMENT
Fiscal Year Ended June 30, 1986

SOURCE OF FUNDS

Income	
Dues and Service Fees from Members	$ 3,428,920
Private Grants	159,032
Cost Reimbursement Contracts	502,593
Special Services	5,508,615
Journal of Medical Education	90,105
Other Publications	382,871
Sundry (Interest $1,873,349)	2,996,831
TOTAL SOURCE OF FUNDS	$13,068,967

USE OF FUNDS

Operating Expenses	
Salaries and Wages	$ 5,228,205
Staff Benefits	972,501
Supplies and Services	3,556,501
Provisions for Depreciation	351,401
Travel and Meetings	1,203,911
Contracted Services	578,194
Net Loss on Disposal of Fixed Assets	1,085
TOTAL EXPENSES	$11,891,798
Increase in Investment in Property and Equipment (Net of Depreciation)	551,236
Transfer to Executive Council Reserved Funds for Special Programs (Decrease)	(206,688)
Reserve for Replacement of Equipment	280,763
Increase in Restricted Fund Balances	45,133
Increase in General Purposes Funds	506,725
TOTAL USE OF FUNDS	$13,068,967

AAMC Membership

	1984-85	1985-86
Institutional	127	128
Provisional Institutional	1	0
Affiliate	16	16
Graduate Affliate	1	1
Subscriber	13	13
Academic Societies	79	82
Teaching Hospitals	435	436
Corresponding	35	30
Individual	1,074	1,005
Distinguished Service	68	68
Emeritus	60	53
Contributing	5	5
Sustaining	10	9

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