Welcome to the 30th annual meeting of the American Society of Nephrology (ASN).

My first task is a sad one. About two weeks ago, one of the giants of nephrology—and a former President of the Society, Carl W. Gottschalk—died. To honor Dr. Gottschalk, the ASN Council has decided to retitle our Research Scholar Award, the Carl W. Gottschalk Research Scholar Award, Dr. Suki, the incoming President, plans further recognition at next year's meeting in Philadelphia. Please join me in a moment of silence in his memory.

I will present, first, a few highlights of our meeting; second, some of the major activities of the ASN during the past year; and third, what you told us about yourselves when you completed that rather long membership survey last spring. Finally, my major goal is to inspire and mobilize the members of our Society to recruit more U.S. medical graduates into nephrology. To do otherwise would be to stand idly by observing the process of death of our profession, perhaps not by cell necrosis, but by apoptosis. We must have new growth genes in our discipline!

Highlights of 1997 Meeting

This meeting was assembled by a very hard-working Program Committee, chaired this year by Roger Wiggins (Table 1). The Committee begins its work before the preceding ASN meeting, and continues during the year with four weekend meetings of the whole group and with numerous additional conference calls and discussions. Two hundred and twenty more members of the Society from the United States and abroad reviewed and selected our abstracts. This year is the first meeting of ASN that incorporates the National Kidney Foundation (NKF) Fall Scientific Meeting. The Vice Chair—this year, Dr. Bourgoignie—and two other members of the Committee were chosen by the NKF. Dr. Narins is the Director of Medical Education for ASN, and Chairs the Post-Graduate Education Committee, which is responsible for formulating the very popular Short Courses. The Post-Graduate Education Committee also includes representation from the NKF and the Renal Physicians Association. Informally, we consult the American Society of Pediatric Nephrologists about our Pediatric Member—in this case, Bill Harris—and the American Society of Transplant Physicians, about the selection of our transplant member, Larry Turka. Finally, the Chairman for the subsequent year's ASN Program Committee—Dr. Arnaout, for Dr. Suki's Program Committee—attends all meetings and envisions how to run an even better meeting the next year. The Society, its Council, and I owe a great debt to our Committee, which functioned as an integrated group with only one goal: to put on the best renal meeting in the world. For that, I acknowledge the effective leadership of Roger Wiggins.

Sitting in the front row is our first female state-of-the-art lecturer, Dr. Cheryl Walker from Texas. Yes, Women in Nephrology. Thirty years is too long, but I believe that this will now become a habit! On Monday morning, our first state-of-the-art plenary symposium will highlight a most important concept (live, unrelated donor transplant) that, if fully implemented, will substantially increase the rate of renal transplantation. Reflecting the increasingly international character of this meeting, just over half of the approximately 3400 abstracts are from outside the United States. In response to your requests, we have created "Pathways"—you can see them in the front of the abstract book—to guide you through this increasingly complex meeting. We look forward to hearing whether you find these useful. These Pathways reflect the determined efforts of the Program Committee to satisfy, on a daily basis, the differing educational interests of the various groups represented within ASN. We are old-fashioned, perhaps, but we believe that oral presentation of data is of value to young investigators, especially when the presentation is to a distinguished, but supportive, scientific audience. We have doubled the number of oral presentations.

In keeping with the high priority we are giving to increasing our gene pool, the Council and I are welcoming 88 residents who are considering training in nephrology. Please identify them, welcome them, and ensure that they enter nephrology training! Our Washington representative, Jill Rathbun, and the Council have been promoting our Workforce Data to restore direct graduate medical education Medicare funding for renal fellowships. Because of our intention that the rapidly growing discipline of Outcomes Research and Epidemiology become an integral part of our science, we have initiated a two-day program on this discipline during Renal Week (which includes the meeting and the few days before it). Dr. Andrew S. Levey and the Program Committee that planned that event will hold a meeting later this morning for those of you who indicated that you were interested in joining a scientific advisory group in this area. The purpose of the group is to advise the Council on this discipline; help plan educational programs during Renal
Week and, possibly, at other times; and to make sure that members interested in Outcomes Research remain enfranchised within ASN. Just as we struggled 10 years ago to weave molecular genetics into our fabric, we now want strong skeins of outcomes research as a prominent component of our educational clothing. If this experiment is successful, we will develop other scientific advisory groups.

We are also just beginning to explore the concept of a clinical trials network, perhaps for North America. Certainly, our cardiovascular and oncological colleagues seem to be way ahead of us in this regard. With Ms. Rathbun’s leadership, we have developed a grassroots lobbying group of MDs, now numbering 350. Our goal is to increase the number to 500 at this meeting. We hope you will attend the booth that has been set up for this purpose.

We have excellent relationships with the new kidney, urology, and hematology (KUH) Director, Dr. Josephine Briggs, and the NIH budget news is good. Now is the time for all investigators to increase grant submissions to National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), especially in areas related to diabetes. An important NIH conference at this meeting will discuss these issues further. We are substantially increasing our Society’s annual investment in research grants, and we will work cooperatively with NIH to supplement some R29 First Awards from $75,000 to $100,000 per year to increase the chances for the success of these important young investigators. Prior to this meeting, during this renal week, we have had four successful educational conferences. Also, our annual Board Review under Dr. Robert Narins’ direction has been wildly successful. We are increasingly incorporating the Up-To-Date Program into our educational programs. A new development will be a series of CD-ROM Grand Rounds from the best academic centers in the United States. These will be designed to provide the most current ideas and therapies in difficult areas of nephrology. Our Journal is flourishing under Craig Tishen’s editorship. We are pleased with the increasingly strong science published in the Journal of the American Society of Nephrology.

As you know, we will now have a pediatrician, Dr. Norman J. Siegel, on the Council. To achieve this, the nominating committee provided three outstanding pediatric nephrologists as candidates for your consideration. In the normal course of events, the elected individual will become President in 2003, ten years after pediatrician Alfred F. Michael’s presidency. Such inclusiveness of our various disciplines is important for the future success of our Society.

I have already mentioned our grassroots activities. Ms. Rathbun has also produced a key contact network guide to assist you in approaching Congress in the most effective way. Your activities, especially with your local congressmen and senators, really do have an effect. Our contribution to increasing NIDDK support from virtually the lowest to the highest percent increase among the Institutes was real. We are more active and more productive in these areas than before, and much of the success in this area is owed to those of you who have helped in the grassroots efforts. For the first time we influenced congressional Veterans Affairs report language on research in kidney disease. In the Graduate Medical Education (GME) funding carve out, we pitched in successfully on the side of academic medicine and graduate medical education versus the insurance companies who were “stealing” the GME money as part of the payment for Medicare Managed Care while accepting no responsibility for GME.

The training program directors under the leadership of Dr.
Tomas Berl have been active in the resident recruitment program and in discussing with the Residency Review Committee (RRC) the research training requirements for our fellows. Dr. Kumar, the previous chair, coordinated the development of a written curriculum for nephrology, which has been published in the Journal (1) and which is so effective that it is being borrowed by the International Society of Nephrology (ISN) to be used in other countries. We have encouraged the Nephrology Program Directors to suggest appropriate faculty for study section memberships, and have pushed for more renal grants to be submitted as already discussed. The Training Program Directors have provided our share of a joint committee with the American Society of Transplant Physicians (ASTP) to determine how to best accredit those centers equipped to train medical transplant leaders during a third year of fellowship experience.

The Council of American Kidney Societies (CAMS) continues to coordinate our efforts in many areas, including lobbying in Washington, selection of our priorities for clinical practice guidelines, and determining who should take the lead with specific guidelines. We wish to ensure that the nephrology profession, rather than the managed care companies, leads in the utilization of these guidelines to evaluate our clinical performance and for purposes of credentialing.

As you know the American College of Physicians (ACP) and the American Society of Internal Medicine (ASIM) are actively involved in a merger. The joint body will have an important committee on subspecialty societies. CAMS has facilitated selection of a single representative to that committee. Furthermore, we are encouraging all other subspecialty societies to also avoid divisiveness in their representation.

Our relationship with the Renal Physicians Association (RPA) has evolved satisfactorily, with clear delineation of our mutual responsibilities. We have presently four, soon to be five, joint committees with two-thirds representation from RPA and one-third from ASN; financial support for these activities flows in the same proportion. We will jointly support guidelines on initiation of dialysis and pre-end-stage renal disease (ESRD) treatment. Important negotiations with the American Nephrology Nursing Association are under way to consider how the two professions can best work together to meet the needs of ESRD patients.

We have agreed to mutual involvement in this meeting and the RPA spring meeting with the view that this can be synergistic for each meeting. We cooperated closely on a Capitol Hill Day immediately before the RPA meeting this spring, and intend to continue that cooperation.

We have coordinated with ASTP our position to the United Network for Organ Sharing regarding criteria for accrediting MD medical transplant directors who obtain a third year of training, and, as already mentioned, we have a joint ASTP/ASN Committee determining criteria for accrediting the training programs for education of these future medical transplant directors.

This meeting is in itself an example of our cooperation with NKF. Together with NKF and NIH, we are cosponsoring an important meeting in June on the improvement of ESRD mortality rates as a follow-up of the so-called "Parker-Hull" Dallas meeting a few years ago, which directed attention to our serious problems in the United States with mortality on dialysis. Also, we are coordinating our research funding. NKF will support KO8 training supplements, and ASN will supplement First Awards to improve the chances of long-term success for our young investigators.

In these difficult times, coordination and avoidance of duplication of our efforts is becoming more important. This is why I stress these collegial efforts by the relevant kidney societies.

**ASN Membership Survey**

The purpose of this survey was to determine your level of satisfaction with the Society's benefits and services; to determine whether we are addressing the issues and trends that you believe are important; and to learn of the direction you wish the Society to move in the future to establish our priorities and strategic objectives.

The survey was mailed to 6000 active members. Active membership in the Society requires residence in North or Central America. There was a 30% response rate, with 93% active members and 88% actually working in the United States. We can be 95% sure that the results contained in this report (±2%) are representative of all 6000 ASN members.

Ninety-one percent of our members are MDs and 13% are PhDs, with a few having both degrees. Sixteen percent are women, and the ethnic breakdown is 78% Caucasian, 13% Asian, 4% Hispanic, and 2% African-American. The mean age is 48 years, and 54% have been in the Society for at least 10 years.

Seventy-four percent of our membership would choose nephrology again. Fifteen percent would not, and 11% are uncertain. In keeping with these sentiments, 80% of our members are either satisfied (57%) or extremely satisfied (23%) with their career as a clinician or research scientist in nephrology; 8% are dissatisfied and 9% are neutral on this issue.

Clinicians spend 42% of their time with dialysis patients, a percentage close to that noted in the workforce study (2). Eighteen percent of the time is spent in the Intensive Care Unit (ICU), which is considerable, and illustrates our vigorous involvement in critical care medicine. You spend 15% of your time in the care of transplant patients. Overall, our clinicians spend 81% of their time in nephrology compared with other areas of clinical medicine.

The percentage of nephrologists performing various procedures each year is shown in Table 2. Thus, for continuous arteriovenous hemofiltration just over one-third never perform the procedure and one-third perform fewer than 12 per year. Note the very high percentage of members who never perform access declotting or peritoneal catheter placement. From the credentialing point of view, nephrologists practicing in groups may have to allow one or two members within their group to concentrate on these procedures in order to maintain both their skills and cost effectiveness. Our cardiology colleagues have

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* More details on the survey will be provided in the ASN quarterly newsletter.
voluminous and for reimbursement.

of nephrologists.

continuous arteriovenous hemofiltration.

one meeting, attends any two-year period 80% of

As for the ASN meeting, on average, 50% of our membership

and we are currently very dependent on IMGs (like me

59% in 1992 to 47% in 1996 (4). IMGs, furthermore, specialize at about a 70% rate, whereas USMGs do so at around 40%. From recent discussions with house staff, I would forecast that the U.S. medical graduate (USMG) subspecialization rate could well fall to about 30%.

Nephrology Manpower

The workforce data were published in a supplement to our Journals (2) in May. A mathematical model was established so that the effect of changing important variables could be determined. These are my selections for the variables in that model for the last three years of the millennium (Table 3). Because this year is the 25th anniversary of the initiation of the Renal Medicare Program, and there was a large entry of internists into nephrology training 25 years ago, many nephrologists will be retiring over the next decade. ESRD growth rates are about 7% now, and I have somewhat arbitrarily established a 5% rate for this coming period. Because of some increased involvement of allied professions as physician extenders, I have estimated the reduction to 90% of the present level of M.D. nephrology involvement in renal patient care. We are also hopeful of some fall in the ESRD mortality rate. These variables engender a conservative estimate that requires 440 new trainees per year. This is a conservative estimate for several reasons, but especially because it assumes that all new trainees will spend 100% of their time in the care of ESRD patients compared with 40% for existing nephrologists. Furthermore, there is a 20% fail rate in the Board examination, and it may not be possible in the future for nephrologists without subspecialty board certification to participate in managed health care.

The number of nephrology fellows entering training between 1992 and 1996 is shown in Table 4. An optimist might see a small increase in the number for 1996. The 1997 data are not yet available. In 1996, 35% of General Internal Medicine (GIM) residents were women and 41% were international medical graduates (IMGs); in comparison, only 24% of nephrology trainees were women and the IMG rate was higher at 59% (3). Clearly, we need to concentrate on recruiting more women, and we are currently very dependent on IMGs (like me and the incoming President, Dr. Suki). Only 125 U.S. medical graduates entered nephrology training in 1996 (3).

Two ongoing changes in GME are very likely to affect our output of trained nephrologists. The subspecialization rate within GIM has fallen from 59% in 1992 to 47% in 1996 (4). IMGs, furthermore, specialize at about a 70% rate, whereas USMGs do so at around 40%. From recent discussions with house staff, I would forecast that the U.S. medical graduate (USMG) subspecialization rate could well fall to about 30%.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Never</th>
<th>&gt;50/Year</th>
<th>Most Common</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAVH/CAVHD</td>
<td>37</td>
<td>8</td>
<td>34% &lt;12/Year</td>
</tr>
<tr>
<td>Renal biopsy</td>
<td>12</td>
<td>12</td>
<td>39% &lt;12/Year</td>
</tr>
<tr>
<td>Temporary vascular access</td>
<td>24</td>
<td>31</td>
<td>23% &gt;50/Year</td>
</tr>
<tr>
<td>Access declotting</td>
<td>59</td>
<td>11</td>
<td>59% Never</td>
</tr>
<tr>
<td>procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peritoneal catheter placement</td>
<td>55</td>
<td>2</td>
<td>55% Never</td>
</tr>
</tbody>
</table>

Table 2. Frequency of procedures (%)

Table 3. Nephrology manpower requirements for years 1998 to 2000

| Rate of growth ESRD          | 5% |
| Level of physician FTE in renal patient care versus now | 90% |
| ESRD mortality rate versus now | 90% |
| Needed new trainees          | 440 |

Data from J Am Soc Nephrol 8[Suppl 9]: S1–S4, 1997. ESRD, end-stage renal disease; FTE, full-time equivalent.

* Assumes that (1) New trainees 100% in ESRD versus 40% for existing nephrologists and (2) all nephrologists completing training can practice even if only 80% pass the Board examination.
Government regulations both for GME reimbursement and for immigration of IMG MDs, whether we like it or not, are very likely to diminish the entry of IMGs into residency training. Indeed, virtually all relevant societies and agencies have advocated the so-called 110% rule, that the number of approved and funded residencies be reduced to a total adequate for training only 110% of graduating U.S. senior medical students. At the present time, 40% of R1 entrants into GIM training (at the intern level) are IMGs (3). The marked effect such rules will have on the number of entrants into internal medicine is clear. If the IMG entry rate into nephrology falls to roughly one-third of the present rate, the number of fellows entering nephrology training becomes 190 per year. This number is considerably less than half of the number we will require based on conservative estimates.

While recognizing the continuing important contribution to nephrology by IMGs, we must increase annual entry rates of USMGs into nephrology. Currently, 340 fellowships are available according to recently published data (3). Medicare support for direct graduate medical education funding for subspecialty training after completion of GIM training has ceased in all subspecialties except geriatrics. We are seeking a similar exception based on the need for support of our training. We have a strong case because our patients are Medicare-supported, and the major source of federal GME funding is also from Medicare.

The pools from which we must recruit USMGs are outlined in Table 5. Twenty-five percent of USMGs currently enter internal medicine training, and fewer than half go on to train in all of the subspecialties of internal medicine (3–6).

A total of 125 USMGs entered nephrology training in 1996. If we postulate a reduction of IMG entry to one-third of the present level, then 375 American graduates will have to enter nephrology annually in the next few years to achieve the goal of a total of 440 trainees. The research training pool is also dependent on the size of the total training pool.

The new and improved investigator pathway recently approved by the American Board of Internal Medicine is an important additional tool that we must use to facilitate the careers and increase the numbers of our basic and clinical investigators. In this pathway, both internal medicine and subspecialty clinical training are truncated so that board eligibility can be offered in six years, with three years available for virtually full-time research training. If the investigator decides to return to a career in clinical practice, the reduced years of clinical training must be made up. Candidates on this pathway are eligible for GIM Boards in the fourth year and for nephrology boards in the sixth year.

### Table 4. Nephrology fellows entering training*

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<tbody>
<tr>
<td></td>
<td>315</td>
<td>311</td>
<td>303</td>
<td>316</td>
<td>334</td>
</tr>
</tbody>
</table>

*Data from the National SGIM Survey, American Association of Medical Colleges, November 1996.

### Table 5. Annual entry rates of USMGs into training in internal medicine and its subspecialties*

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>USMGs</td>
<td>16,000</td>
<td>100</td>
</tr>
<tr>
<td>↓ IM</td>
<td>4,000</td>
<td>25</td>
</tr>
<tr>
<td>↓ All SS (IM)</td>
<td>2,800</td>
<td>18</td>
</tr>
<tr>
<td>↓ Nephrology (Now)</td>
<td>125</td>
<td>0.8</td>
</tr>
<tr>
<td>↓ Nephrology (Need)</td>
<td>375</td>
<td>2.4</td>
</tr>
</tbody>
</table>

*These numbers are rounded off and approximate. The data are obtained from American Board of Internal Medicine, News Update, Fall 1997; National Resident Matching Program American Association of Medical Colleges, April 1997; National SGIM Survey, American Association of Medical Colleges, November, 1996. These data are not cohort data for serial years, but a snapshot of the current situation. USMGs, U.S. medical graduates; IM, internal medicine; SS, subspecialties.

### Why Are So Few USMGs Entering Nephrology Training?

As we have discussed, overall fewer internal medicine residents are entering subspecialty training because of the tremendous publicity for the "politically correct" view that all subspecialties are now over-subscribed. This message has been received loud and clear by our residents, and we must fight hard to change the view about nephrology. What do our internal medicine residents see lacking in our training programs, even if they are convinced that job opportunities exist in nephrology?

Obviously, they see too few USMGs (about 250 in the two-year programs of 137 separate training programs). In most programs, the renal fellows are regarded as the hardest working, perhaps along with cardiology and oncology fellows. Because of the reduced number, they are frequently in a more demanding call system. The residents often see only our most difficult patients who are very complex and may have a poor quality of life. In general, they do not see our successes in the ambulatory sector, including patients who are fully restored to normal activities by transplant, or those who are working and doing very well on chronic dialysis. Nephrologists perform fewer procedures, and they may allow radiologists to perform biopsies and renal ultrasound, and permit critical care specialists to control ICU procedures including continuous arteriovenous hemofiltration. Contrast this situation: a resident is excited when a cardiology fellow performs a bedside echo to demonstrate an incompetent aortic valve, or a vegetation on a mitral valve in a patient with subacute bacterial endocarditis, but we cannot do the equivalent, for example, for cystic or obstructed kidneys in patients with acute or chronic renal failure.

There are solutions. We must publicize our practice opportunities and the data supporting them, not only to internal medicine residencies in university settings, but to all internal
medicine residencies. We must seek the help of the Association of Program Directors in Internal Medicine. We must work to restore direct GME funding for subspecialty training, in areas which future shortages can be adequately documented. We must ride on the back of our exciting science, and recreate the earlier excitement in fluid, electrolyte, and acid-base disturbances, including our ability to understand these events at the molecular level. We must remember that residents, during their rotations in nephrology and in the wards, observe very carefully the fellows' happiness and education-to-service ratios, and that these are usually in direct proportion to one another.

Nephrologists are often among the best-regarded teachers and skilled clinicians, and these role models must promote our discipline with the residents. Difficult as it may be, we must demonstrate that we can care for all aspects of clinical nephrology. This will also become necessary under capitation for ESRD patients; thus, we can exploit this economic necessity to make our discipline more attractive to potential trainees. We must strive to take a leading role in capitated care of nephrology patients and must not accede to the control of the dialysis company megagroups and hospital systems. We must also accept responsibility for primary care of the ESRD patient. These are captive patients, and we have no excuse for not achieving the best immunization, mammography rates, etc. We must recognize, and demonstrate to our trainees that we recognize the importance of nurses, dietitians, social workers, and physician assistants in delivering care to our patients, even as we take full responsibility for that care.

Evidence-based medicine, outcomes research, and clinical trials are essential for as many of our patients as possible. We have always had a discipline based strongly on science and physiology; let us make clinical care similarly dependent on scientific evidence. Finally, and most importantly, let us stop whining and promote our discipline.

Is this an impossible task? No! The magnitude of this problem is shown in Table 6. We need to increase the number of nephrology trainees from an average of one per medical school class to three per medical school class and to recruit one in seven residents—hopedly the most able ones—entering the subspecialty of internal medicine. We were very close to these numbers in our golden years, in the late 1970s and early 1980s (5).

Table 6. Dimensions of the task

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Needed</th>
</tr>
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<tbody>
<tr>
<td>125 medical schools</td>
<td>1 per/class</td>
<td>3 per/class</td>
</tr>
<tr>
<td>4000 IM residents</td>
<td>1 in 33</td>
<td>1 in 11</td>
</tr>
<tr>
<td>(1 per residency)</td>
<td>(3 per residency)</td>
<td></td>
</tr>
<tr>
<td>2800 SS residents</td>
<td>1 in 22</td>
<td>1 in 7</td>
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* These numbers are rounded off and approximate. Abbreviations as in Table 5.

Is this increase achievable? The marketplace has worked remarkably well in other disciplines. Thus, between 1992 and 1996, the number of graduating senior medical students from U.S. medical schools choosing anesthesiology training fell by 82%, whereas the number selecting emergency medicine increased 60%, and family practice 63%. There was a fall by about one-third in GI and rheumatology fellows (4–6). More recent data in the past two years indicate that there was a 60% drop in American graduates entering radiotherapy training (3,5).

Conclusion

If we believe our own Workforce Data, if we believe that ESRD patients can best be managed by nephrologists—and there is now data to support this—if we believe that we are best prepared to diagnose the cause and prevent the progression of renal disease, if we believe that scientists trained in nephrology are most likely to direct translational research on elucidating and preventing renal disease, and if we believe that nephrologists are necessary as teachers to ensure that primary care physicians best understand the presentations of acute and chronic renal failure and the management of fluid, electrolyte, and acid-base problems, then we must see to our seed corn.

Every member of the ASN who is active in science, teaching, or clinical practice can have some impact on this quest. Renal physiologists and other basic renal scientists can excite medical students about our discipline in the first two years of medical school training and provide data on the need for more nephrologists. Not only those of us who are in full-time academic medicine, but all of you can make a difference when you have contact with medical students during the clinical years and with residents in training. Let us show them by our clinical excellence and strong clinical science that this profession is worthy of their consideration. Let us make sure they know of our patients' need for more U.S. residents in nephrology. Each year at this meeting from now on, we should consider the latest data on the entry of U.S. and IMG medical residents into nephrology training. I can think of no more important task for nephrology in the next few years.

In closing, my thanks for your support and for the privilege of serving as President; my thanks also to Council for its very substantial help during the past year; and my gratitude to Judy Thomas, the superb Executive Director of ASN, and her staff.

References
3. Graduate medical education [Appendix II]. JAMA 278: 775–784, 1997
4. American Board of Internal Medicine, News Update, Fall 1997
5. National Resident Matching Program, American Association of Medical Colleges, April 1997