ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 14, 1971

TO: Council of Academic Societies

FROM: James V. Warren, M.D., Chairman

SUBJECT: CAS Meeting February 12, 1971, Palmer House, Chicago

Enclosed is a copy of the program and agenda materials for the next CAS meeting. I urge you to plan to attend this important meeting.

The morning session will deal with the changing role of basic science in medical education. The CAS Executive Committee felt that this was an area of urgent consideration by this organization. As part of the current ferment in medical education, we are being asked to reassess the role of basic science. We are being asked to produce medical students with programs of greatly shortened basic science component and the clinical years spent primarily in the community hospitals. Some are either recommending or actually instituting programs with the basic sciences taught by a university or community college some distance from the medical school or by the clinical departments of the medical school. In either way, there is not the immediate resource of a basic science department that we have known so well in recent years. Much basic science teaching is now "verticalized." This has brought changing interrelationships among the basic scientists and the quality control of teaching. These discussions merit the concern and action of both the basic scientist and the clinician.

Even in the short life of the Council of Academic Societies, it has changed appreciably in its make-up and apparent mission. At the CAS annual meeting in Los Angeles, there was considerable discussion regarding the future of the organization, particularly with reference to its membership and goals. In response to a motion passed at that meeting, the Executive Committee appointed a subcommittee to study this issue and prepare several options for the future pattern of the CAS. A copy of this subcommittee's report to the Executive Committee is enclosed so that the membership may have ample opportunity to review it before the February 12 meeting. We would appreciate having your thoughts in this matter. Please write me at the AAMC headquarters. In this way, the Executive Committee can also have the benefit of your thinking at its February 11 meeting, when the report will first be considered. Any plans, of course, must be interdigitated with the total program of the AAMC. If the CAS is to become a useful and productive organization, we should work out a plan which will give both a sense of belonging and a sense of accomplishment to its members. This program will also serve to introduce Dr. August Swanson, who is soon to become a staff member of the AAMC and who will be heavily concerned with its academic activities. Mr. Joseph Murtaugh will attempt to set forth some of the basic issues confronting the further evolution of medical education and research in the context of the broader struggle to arrive at a more comprehensive National Health Policy.

I would again ask that you make every effort to attend and encourage your colleagues to do so. Although the official two representatives from each society are the ones involved in voting at the CAS business meeting, all members of the constituent societies and other interested parties are invited to attend and participate in the deliberations of this meeting.

Encls. Use the hotel reservation card that appears in the AMA brochure.

COUNCIL OF ACADEMIC SOCIETIES
PROGRAM

Palmer House, Chicago, Illinois
PDR 18
February 12, 1971

Morning Session - THE CHANGING ROLE OF BASIC SCIENCE IN MEDICAL EDUCATION

Moderator: Emanuel Suter, M.D.
University of Florida

9:00 a.m.	Introduction	Dr. Suter
9:05 a.m.	Experience at the University of California, San Diego	Clifford Grobstein, Ph.D.
9:25 a.m.	Questions	
9:30 a.m.	Experience at the University of Washington	Thomas Morgan, Jr., M.D.
9:50 a.m.	Questions	
10:00 a.m.	Break	
10:30 a.m.	"A basic scientist looks at his role in medical education"	Manfred Karnovsky, Ph.D. Harvard Medical School
10:50 a.m.	Questions	
10:55 a.m.	"A clinical scientist looks at the role of basic science in medical education"	Donald Seldin, M.D. University of Texas - Southwestern
11:15 a.m.	Questions	
11:20 a.m.	Panel Discussion	
12:15 p.m.	Summary	Dr. Suter

AFTERNOON SESSION
2:00 - 5:00 p.m.
(See over)

COUNCIL OF ACADEMIC SOCIETIES
PROGRAM

Palmer House, Chicago, Illinois
PDR 18
February 12, 1971

Afternoon Session - FUTURE CHALLENGES TO THE CAS

Presiding: James V. Warren, M.D.
Chairman, CAS

2:00 p.m.	Introduction	John A. D. Cooper, M.D. President, AAMC
	"National health policy planning-- a choice between dilemmas"	Joseph S. Murtaugh Director, Department of Planning and Policy Development, AAMC
	"Problems and prospects"	August G. Swanson, M.D. Director, Department of Academic Affairs, AAMC
	* "Future planning"	Sam L. Clark, Jr., M.D. Chairman-Elect, CAS
	Business Meeting Report on Biomedical Research Policy	Louis G. Welt, M.D. Chairman, CAS Committee
	* Report on Graduate Medical Education	Thomas D. Kinney, M.D. Chairman, CAS Committee
5:00 p.m.	Adjournment	

* Agenda materials enclosed

COUNCIL OF ACADEMIC SOCIETIES
Alternatives for the Future*

I. Do away with the CAS and substitute for it an organization of medical school faculty representatives.

A. Whom would these faculty representatives represent?

1. Would any attempt be made to balance representation between basic and clinical scientists? How many representatives would there be from each school?

2. How would the representatives be appointed? Would they be departmental chairmen or junior faculty members? Would they be appointed by the Dean or by some faculty organization such as a faculty council? How would their representativeness be insured?

B. Who would pay for the travel expenses of these representatives and the costs of the programs to be carried out by them?

II. Retain the CAS.

A. Whom would the CAS represent?

1. Have a relatively open membership that would broadly represent those groups of people interested and active in medical education at all levels - undergraduate, graduate, post-graduate, or continuing.

a. There would be a diversity in the activities and interests of the members, many of whom might have only indirect interest in undergraduate medical education.

b. It would form a large source of talent and both moral and financial support for carrying out the programs of the CAS.

* Prepared by a Subcommittee of the CAS Executive Committee for discussion by the CAS Executive Committee on February 11, 1971 and by the CAS Membership on February 12, 1971.

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c. It would provide a wide base for representation of the voice of American medical education and it would include many of the active participants in the very strong debates that will be upon us in the next decade concerning all levels of medical education. Although these diverse groups probably will not agree on all the issues, the debate can take place within the organization where, hopefully, an atmosphere of reason may be cultivated.

2. A small, exclusive CAS sharply restricted to organizations heavily involved in undergraduate medical education.

a. What would be the criteria for membership?

(1) The numbers of organizations might be limited by such a device as allowing only two organizations per discipline to belong to the CAS. However, there appear to be infinite possibilities for subdividing disciplines, particularly in the clinical subspecialties.

(2) A society could be admitted on the basis of the proportion of its membership that held full-time faculty appointments in medical schools. However, some large basic science organizations such as the biochemists might have difficulty qualifying.

B. What should be the internal structure of the CAS?

1. Continue with the present unstructured arrangement. This would promote dialogue between the diverse societies or its membership and help to hold them together to a common purpose in improving medical education at all levels.

2. Subdivide the CAS into panels in order to limit diversity and increase the commonness of interest.

a. Basic science disciplines versus clinical disciplines.

b. Organizations made up primarily of full-time faculty members versus those made up of primarily part-time faculty members.

c. Organizations concerned with undergraduate medical education versus organizations concerned chiefly with postgraduate medical education. Such subdivisions might give the basic scientists a forum in which they would not feel outnumbered by the part-time clinical faculty (as represented by the colleges), and it might allow different panels to specialize in particular areas of interest concerning medical education. However, it would make more difficult the effort to bring these diverse groups together for common purposes.

January 8, 1971
Draft
CAS Committee on
Graduate Medical
Education

CORPORATE RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

Introduction

The years since the end of World War II have seen the responsibilities of the university-related academic medical complex for all forms of clinical education and training grow. The education and training of these post-doctoral clinical students has become one of the largest programs of the university medical center. Yet the relation of such programs to regulatory agencies independent of the university remains unchanged. Simultaneously problems of financing these programs have become much more involved. The resulting fragmentation of authority and responsibility has been deplored repeatedly. In 1965, in its report, Planning for Medical Progress Through Education, the Association of American Medical Colleges (AAMC) called for broadened university responsibility for graduate medical education (1). The American Medical Association (AMA) has also been deeply concerned with these developments. The two organizations, working in conjunction through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful reexamination of procedures for accreditation of these programs.

1. Coggeshall, L. T. Planning for Medical Progress Through Education. Evanston, Illinois: Association of American Medical Colleges, 1965.

In 1969 the AAMC published a report on The Role of the University in Graduate Medical Education, advocating less fragmentation of authority in this area and focusing of responsibility in the university (2). In light of their growing role in graduate medical education, the component academic medical centers of the AAMC have authorized this statement.

Definition

Corporate responsibility for graduate medical education is defined as the assumption by the university and its collective faculties of the classic responsibilities and authority of a university for all its students and programs in medical education. This implies that the faculty of the medical school will collectively assume the responsibility for the education of clinical graduate students* (interns, residents, and clinical fellows) in all departments and that the education of these students will no longer be the sole prerogative of groups of faculty oriented to individual departments or single areas of specialty practice.

Advantages

Among the advantages inherent in vesting responsibility for graduate medical education in a single identifiable body rather than continuing departmental

2. Smythe, C. McC., Kinney, T. D., and Littlemeyer, M. H. The Role of the University in Graduate Medical Education. J. Med. Educ., 44: September, Special Issue, 1969.

* The use of the word student in this document requires definition. The individuals discussed here have received their doctorate and are engaged in an intensive postdoctoral program of training to become a specialist in one of the areas of medical practice. They are basically students, but usually have important commitments to medical care and teaching. They are, therefore, in some sense practicing physicians and faculty members. There is usually no degree goal, but certification by a specialty board or public acceptance of specialty status are the rewards of this training. In view of these considerations, no single word accurately describes persons in this role and with these reservations the word student will be used in this discussion.

fragmentation are the following:

1. implementation of the continuum concept in medical education;

2. more effective adaption to individual student's rates of progress through the education process;

3. fostering multiple methods for conducting graduate education and thereby enhancing innovation;

4. enrichment of graduate medical education by bringing to it more of the resources of the university and its faculties;

5. promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities;

6. enhancing the principle of determination over educational programs by the individual universities; and

7. promotion of a comprehensive rather than a fragmented pattern of medical training and practice.

The major drawback to such an objective is the hazard of incurring some of the inflexibilities of university procedures and/or dangers of bureaucratization.

Fragmentation of Responsibility for Graduate Education

A further significant fact is that, despite oft repeated disclaimers, specialty board certification does represent a second degree and is the significant license for the higher reaches of American medical practice. The evidence for this allegation is all around us but is found most importantly in attitudes and behavior of the men in practice and of those who make hospital appointments and decide on professional reward systems, both pecuniary and nonpecuniary. This state of affairs is a significant departure from the usually stated theory of license to practice. In the usual formulation, civil government, because of its obligation to protect the people, grants to agencies which it controls the authority and responsibility to decide who shall

be admitted to the practice of a profession. Such agencies characteristically have as their primary charge protection of the best interests of the people. In one fashion or another, through either appointment or election, in the United States they are answerable to state governments. If the specialty boards are indeed de facto licensing agencies, current practices in which they are primarily responsible to their colleagues in their specialties are far removed from usually accepted theories of the nature of civil license.

Graduate clinical training or graduate medical education is now carried out in highly variable clinical settings and since the clinical graduate students are frequently licensed physicians but are primarily in a learning role, the status of these students remains ambiguous. Classically, interns and residents are considered employees of hospitals although medical schools or other professional groups may contribute to their stipends. Interns and residents are denied the practice privileges of physicians not in teaching programs, especially as regards the management of fees for services to patients. They are not usually considered members of the university community especially as regards the management of fees for services to patients, yet their salaries are largely derived from third-party payments based on patient services. Still these students are not usually considered members of the university community.

In the majority of instances, such house officers are pursuing specialty board certification or publicly ascertainable qualification in one of the medical specialties. The duration, content, progress through training, and determination of elegibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are char-

acteristically private, not-for-profit organizations that have substantial autonomy. Universities or hospitals have no direct influence on their policies or actions.

All internships are approved by the Internship Committee of the Council on Medical Education of the AMA. All residency programs are accredited by the Residency Review Committees of the AMA, with the exception of Pathology. The American Board of Pathology directly examines and accredits its residency training programs. The Residency Review Committees are made up of appointees of the specialty sections of the AMA and the appropriate boards, and many of them also have additional appointees from the appropriate Colleges or Academies. The Residency Review Committees are autonomous except for matters of policy and do not have to report back to their parent organizations for ratification of their decisions. The graduate education section of the Council on Medical Education of the AMA provides secretarial assistance and administrative support for the operation of all Residency Review Committees. The concern of the Council on Medical Education for all facets of medical education is a matter of historical record. In the area of graduate education, however, the Council has essentially no direct authority over either the boards or the Residency Review Committees since both function independently and autonomously. However, in practice, its influence is significant. It should be noted that the AMA has its roots in the practice of medicine, and its policies will inevitably and properly always be strongly influenced by current conceptions of the interests of practicing physicians whose direct contact with education has either ended or become a secondary part of their professional activity.

The individual to whom the resident is responsible is his service chief,

program director, or departmental head. Such an individual always has a major hospital appointment, and his authority over a clinical service, and hence over its residents, relates to his role in the hospital. He may or may not have a university connection of significance, ranging from major to only ceremonial. This service chief has had direct responsibility for the content of the program in accord with the requirements of the specialty boards and the Residency Review Committees. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have a considerable autonomy within broad policies.

The medical school or university through its faculty members and affiliated hospitals sponsors and influences a large segment of graduate medical education and accordingly should have a more formal role in its design and operation. It has very real authority, through its influence over hospital policies and the appointments of service chiefs, but it may or may not have real operational responsibility. Its faculty as a group may have no corporate responsibility.

In summary, control of graduate medical education is fragmented among the following settings:

1. hospitals which employ trainees and provide the classrooms and laboratories for their education;

2. specialty boards which determine duration and a portion of the content of training and act as de facto licensing agencies;

3. Residency Review Committees which accredit on a programmatic basis and which in the long haul are answerable to the interests of the practicing profession;

4. service chiefs who on a programmatic basis determine the balance of content and all of the process of graduate medical education; and

5. medical schools and universities which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Attributes of Current System

Today's system has consistently and reliably produced specialists well equipped to care for the disease-related content of their areas of medical practice. In terms of its goals, it has been an acceptably successful pragmatic solution, adaptable to the variety of conditions found in so large and diverse a nation as the United States. If its goals, the replication of highly categorized specialists were now acceptable in terms of the needs of the public, its ambiguities would be tolerable.

Before any new arrangement is adopted, in terms of its stated objectives, it should be noted that these are major strengths of this pluralistic system. The degree of specialization which has been brought about by advancing knowledge calls for parallel evolution of complexity of organization. It is this complexity in fashioning the education of a physician which has created demands for a more holistic approach to the total duration of medical education which a corporate approach in graduate medical education can help provide. The emphasis on major disease and on inpatient care has helped produce a medical care system with serious imbalances.

Unification or Corporate Responsibility in Undergraduate Medical Education

In many ways the situation in graduate medical education today is not unlike that of undergraduate medical education 70 years ago. It is widely recognized that the medical school and its parent university have assumed corporate responsibility for undergraduate medical education. This was the significant reform of 1890 to 1925. The issues facing graduate medical education in the 1970's contain many striking parallels and the solution being suggested

here has many features of that which worked so well for undergraduate medical education two generations ago. In the 1960's medical schools began major undergraduate curricular revisions. These efforts to make undergraduate education more responsive to perceived public needs are generally based on the assumption that the undergraduate educational process is preparing students to enter into a period of postdoctoral training. This combination of predoctoral and postdoctoral education finally produces the polished professional clinician, and the professional school should have as large a stake in the postdoctoral educational process as it has had in the predoctoral.

Corporate Responsibility

Corporate responsibility has been defined for the purposes of this paper as institutional as opposed to departmental or proprietary assumption of the recognized responsibilities of the university as related to students and faculty. These are seven:

1. determination of educational objectives and goals;
2. allocation of resources and facilities to permit realization of these goals;
3. appointment of faculty;
4. selection of students;
5. determination of content and process of educational program;
6. evaluation of each student's progress; and
7. designation of completion of program.

These responsibilities as applied to graduate medical education should be vested in a university and then should be delegated to its medical faculty which in turn should create a program of educational advancement protecting the rights of students and responsive to the requirements of society.

The medical faculty as a faculty should become the body responsible for creating the environment for their activities in graduate medical education, for selecting their fellow faculty members, and for approving the design of programs in graduate medical education including concern for the processes used, the duration and content of learning, and the coordination and inter-relation between various units of the faculty. As a faculty, they should have a voice in the selection of students, with concern for their quality and number. They should also be expected to institute procedures which would allow them to determine the achievement of the appropriate educational level and readiness of the residents to stand examinations for certification by the currently constituted specialty boards.

Implications of the Acceptance by the Universities of Responsibility for Graduate Medical Education

So many agencies and people would be affected by pulling today's fragmented responsibilities together and assigning to universities both the responsibility and authority for the graduate medical education now carried out in their spheres of influence, that the only way to analyze implications of these changes is to look at the various forces involved one at a time.

The University

Administrative, financial, and organizational relations existing between parent universities and their medical schools would not be appreciably altered by this change. Long-range changes could be expected, and these will be touched upon in the following sections.

The Medical School Faculty

There would need to be relatively little immediate change in the day-to-day climate of the clinical faculties of medical schools. More significant

would be the slow but predictable and desirable increase of interaction with other faculties. There would also be a tendency toward greater coordination of activity within the clinical faculty. Presumably, there would be more effective integration of the strengths of various units of the medical center both medical and nonmedical, and this greater coordination could be expected to produce different educational and patient care alignments. Conversely, the faculties might get caught up in such forms as coursework, credits, and examinations.

The advocated organizational patterns can be counted on to precipitate decisions about which aspects of general surgery and medicine should precede and which should follow the M.D. degree. The questions must be faced in any event, and recognition of medical education as a continuum--the responsibility of a single unified faculty--would be a great advantage.

The Graduate School

Assignment of such corporate responsibility within the university will become an important consideration. Although it is conceivable that the graduate school could be the assigned area for such programs, graduate clinical education is so eminently the business of physicians that it makes little sense to locate it in a general university graduate school but rather to retain it in the medical school setting. Actually multiple solutions are possible, and such ambiguities seem tolerable.

Another Degree

The issues of advanced and intermediate degrees in medicine are not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and an important piece of paper from specialty boards (certification of specialty status). The advanced clinical degree has not caught

on in this country despite its trial, especially in Minnesota, and despite practices abroad. A corporate arrangement would demand some formal recognition of the end of the educational sequence. A degree of some sort would almost certainly emerge in time, probably in discoordinate fashion from school to school. As an obstacle to a new plan or organization, the degree issue need not be settled early. However, some will advocate a preliminary degree after medical school, perhaps an intermediate degree a year or two later, and some final degree such as master of surgical science or the like as the university's certification of what each graduate student had accomplished. Any move to imperil the strength of the M.D. degree would be very strenuously resisted. The public has a firm impression of the meaning of the M.D. degree, and any change in university structure that might alter its denotation should be considered with circumspection.

Hospitals

Here truly significant problems begin to emerge. The major educational program of a hospital would become the responsibility of an agency in some instances external to the hospital and governed by a different board. This is a significant shift, and it can be expected that hospitals everywhere will analyze its implications with their own interests in mind, as is only proper. The realities of getting a group of community hospitals or a community and university hospital to organize a single corporate educational program will call for intensive bargaining. It can be predicted that there will be orders of difficulty, from least in a situation in which hospital and medical school are jointly owned and administered by a single board, to most where hospital ownership, operation, financing, and location are all separate. Many of the

issues raised will turn around advantages to the hospitals. As far as financing goes, there would be few differences in today's practices. Organizationally, there might be shifts in the influence of single departments. Operationally, this might emerge as another force toward more comprehensive medical care. In terms of accreditation or approval, the hospital educational program would be approved as a unit. This would mean the number, duration, type of training, and coordination of training offered would be returned to local control by the joint medical school-hospital faculty.

The University, Graduate Education, and Nonaffiliated Hospitals

Although the university medical center initially assumes a corporate responsibility for the graduate education of physicians in its affiliated hospitals, ultimately the need for the university's influence on graduate programs in nonaffiliated hospitals will be necessary for several reasons:

1. A considerable segment of all graduate education is now conducted in nonaffiliated hospitals.

2. University medical centers and their affiliated hospitals cannot educate effectively the total number and type of physicians required.

The relationship created can vary from one institution to another depending upon the educational capability of the nonaffiliated hospital, financial support required, and the desire of the nonaffiliated hospital to participate in a university designed and directed educational program. All such arrangements for cooperative or integrated efforts should be completely voluntary and obviously to the advantage of both institutions.

The Student

At first, there would be very few changes for the people in training. However, more ready access to other departments, readier availability of the

resources of other units of the university, and better coordination in training could be expected to lead to stronger, shorter, and more varied programs. These would all eventually work to the advantage of the students and this type of result for them must be seen as among the major reasons for and major benefits expected from the advocated change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to general university procedures. These university procedures would carry with them the benefits of easier access to all the strengths of the university.

Financing the Educational Component

There is obviously a cost involved in graduate medical education. For years this cost has been absorbed by the residents by deferral of earnings, by the clinical faculties through donation of their time, and by the patients, especially those in tax and philanthropically supported hospitals, through direct charges for hospital services. This system is now challenged by everyone: the residents in their demand for higher salaries, the faculties through the emergence of the full-time system, and the patients who through large third-party payers are challenging the inclusion of any educational costs in charges to patients.

The organization of clinical faculties along corporate rather than departmental lines would have no direct effect on these issues, except for their probable clarification. Expenses should not increase except as academic functions increase. The emerging acceptance of the need to fund service functions by beneficiaries of these services and educational functions by the beneficiaries of these services will shortly bring to a head responsibility for funding of this educational component.of clinical graduate

training. The university will be unable to assume this burden unless it in turn is financed. The general trend to spread costs of higher education widely through society by any of a number of mechanisms is seen as the only way to handle this issue.

The Specialty Boards

The role of the specialty boards would change primarily toward their becoming certifying agencies not exercising direct control over duration or content of training. This again also seems to be a change which in one form or another is clearly on us. The boards will continue to have a major role in graduate medical education through the design and provision of examinations and the certifying of candidates who complete them successfully.

External Accrediting Agencies

The Liaison Committee on Medical Education, the Council on Medical Education of the American Medical Association, Residency Review Committees, and the Joint Commission on Hospital Accreditation are examples of external accrediting agencies. This function must be carried out in order to protect the public. One of the fundamental assumptions surrounding the proposed corporate responsibility for graduate medical education is that the corporate body itself, in matters pertaining to accreditation, would relate primarily to a single external agency and be accredited by it. The proposed Commission on Medical Education is an effort to create such an agency at this time. Its emergence remains in doubt, but if the advocated change does not come about, the universities would need and would indeed demand the organization of some external accrediting and standard maintaining body rather than being answerable to many as they are today. The Liaison Committee on Medical Education

is taking some steps to assure greater responsibility for accreditation in graduate medical education.

Patients and Consumers

No immediate effect on patients and consumers can be predicted at this time. However, since the raison d'être of the whole health care and health education system is to serve the people, the vitality of corporate medical education must eventually rest in its ability to serve the people well. Public input is desirable and has been proposed at a national level. It should be locally determined from medical center to medical center based on local consideration.

The Academic Health Center and Graduate Medical Education

The progressively more secure conviction by the Association of American Medical Colleges that the academic health center should become a focal point for the initiation and operation of programs for research, education, and patient services on a regional basis creates questions concerning goals and methods of attaining them. For the center to have a significant influence upon the regional practice of medicine and the delivery of comprehensive health services, it appears essential for the center and specifically the university to assume a corporate responsibility for the graduate education of physicians. Among the reasons for the need for this assumption are the fact that (a) a portion, frequently a large one, of the service provided to the community is carried out by interns and residents; (b) the total interdisciplinary resources of the university can be brought to bear upon the standards of health care through interns and residents; and (c) a continuing relationship for educational purposes may be created through interns and

residents when they enter the community to practice.

Without the university's acceptance of the corporate responsibility for the total formal education of physicians, their efforts to influence services provided to the community and the appropriate education of physicians to provide them will be less than effective.

[Designees]

ROLL CALL — ASSOCIATION OF AMERICAN MEDICAL COLLEGES — 3)

SOCIETY	REPRESENTATIVE(s)	DESIGNEE	NOT PRESENT
Academic Clinical Laboratory Physicians & Scientists	George Brecher		✓
American Association of Anatomists	Burton L. Baker Sam L. Clark, Jr.	✓ ✓	
Amer. Assn. of Chairmen of Depts. of Psychiatry	Bernard C. Holland L. Jolyon West	✓	
Amer. Assn. of Neurological Surgeons	Eben Alexander, Jr. Henry G. Schwartz	✓ Mullan	
Amer. Assn. of Neuropathologists	George Collins Wolfgang Zeman	✓	
Amer. Assn. of Pathologists & Bacteriologists	Kenneth M. Brinkhous Patrick J. Fitzgerald	✓	
American Assn. of Plastic Surgeons	James E. Bennett Stephen R. Lewis	✓	
American Assn. of Chairmen of Medical School Depts. of Pathology, Inc.	Thomas D. Kinney	✓	
American Neurological Association	Kenneth Magee Samuel A. Trufant		✓
American Pediatric Society	Charles A. Janeway William B. Weil, Jr.	✓	
American Physiological Society	R. E. Forster Arthur B. Otis	✓	
Amer. Society of Biological Chemists, Inc.	Ronald W. Estabrook Robert Harte	✓ Manfred L. Karnovsky	
American Surgical Association	William D. Holden Lloyd M. Nyhus	✓	
Assn. of Medical School Pharmacology	George H. Acheson	✓ Handwerker	
Assn. of Academic Physiatrists	Murray M. Freed	✓	
Association of American Physicians	Eugene A. Stead, Jr. Louis G. Welt	✓	
Association of Anatomy Chairmen	Jack Davies David G. Whitlock	✓ Clark	
Assn. of Chairmen of Depts. of Physiology	Robert Berne D. C. Tosteson	✓	
Assn. of Medical School Pediatric Department Chairmen, Inc.	William Thurman Ralph J. Wedgwood	✓	
Assn. of Professors of Dermatology	Philip C. Anderson Raymond R. Suskind	✓	
Assn. of Professors of Gynecology and Obstetrics	John Donovan	✓	

SOCIETY	REPRESENTATIVE(S)	DESIGNEE	NOT PRESENT
Association of Professors of Medicine	Ludwig Eichna Robert Petersdorf	✓	
Assn. of Teachers of Preventive Medicine	Charles E. Lewis Kenneth Rogers	✓ Huntley	
Association of University Anesthetists	John J. Bonica Robert M. Epstein	Ed Brenner Ed Matthews	✓
Assn. of University Professors of Neurology	Maynard Cohen David Daly	✓	
Assn. of University Professors of Ophthalmology	Frank C. Newell David Shoch	✓	✓
Association of University Radiologists	John A. Campbell Solomon Schwartz	✓	
Joint Committee on Orthopaedic Research and Education Seminars	Paul H. Curtiss, Jr. Charles F. Gregory	✓	
Society of Academic Anesthesia Chairmen, Inc.	Peter P. Bosomworth Frank Moya		✓
Society of Chairmen of Acad. Radiology Departments	Herbert L. Abrams Sidney W. Nelson	✓	
Society of Surgical Chairmen	David C. Sabiston, Jr. G. Tom Shires	✓	
Society of University Otolaryngologists	Roger Boles James B. Snow, Jr.	✓	
Society of University Surgeons	Theodore Drapanas Richard H. Egdahl	✓	
Society of University Urologists	William H. Boyce John T. Grayhack	✓	

AMERICAN SOCIETY OF BIOLOGICAL CHEMISTS
— INCORPORATED —

ROBERT A. HARTE, EXECUTIVE OFFICER
9650 ROCKVILLE PIKE
BETHESDA, MARYLAND 20014

PHONE:
AREA CODE 301
530-3200

Serial 139
25 January 1971

Dr. James V. Warren
Chairman
Council of Academic Societies
Association of American Medical Colleges
1 Dupont Circle
Washington, D.C., 20036

Dear Dr. Warren:

Unfortunately, my schedule is such that I will be out of the country at the time of the meeting of the Council of Academic Societies on 12 February 1971 and will therefore be unable to attend. With the concurrence of Dr. Eugene P. Kennedy, the President of this Society, Dr. Manfred L. Karnovsky of Harvard Medical School is being asked to take my place at the meeting of the Council and together with Dr. Estabrook, represent this Society at that meeting.

Dr. Karnovsky, of course, will be in Chicago in any instance since he is listed as a speaker at one of the interesting sessions which are planned.

With best wishes for a most successful meeting.

Yours very sincerely,

Robert A. Harte

RAH/map

CC: Dr. Ronald W. Estabrook
Dr. Manfred L. Karnovsky
Dr. Eugene P. Kennedy

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American Medical Association
535 North Dearborn Street
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Attention: Secretary
Council on Medical Education

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

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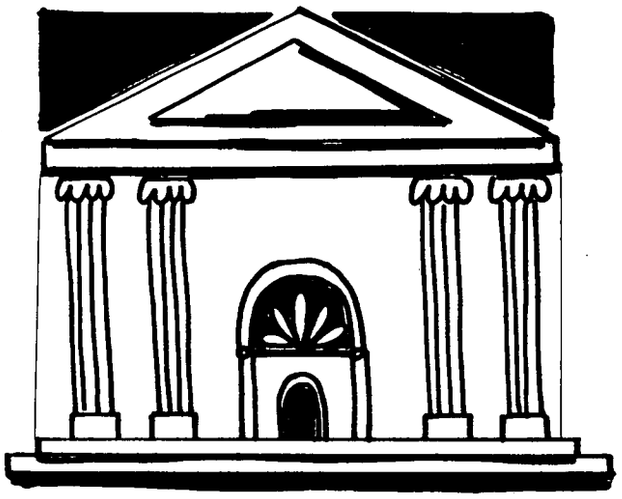
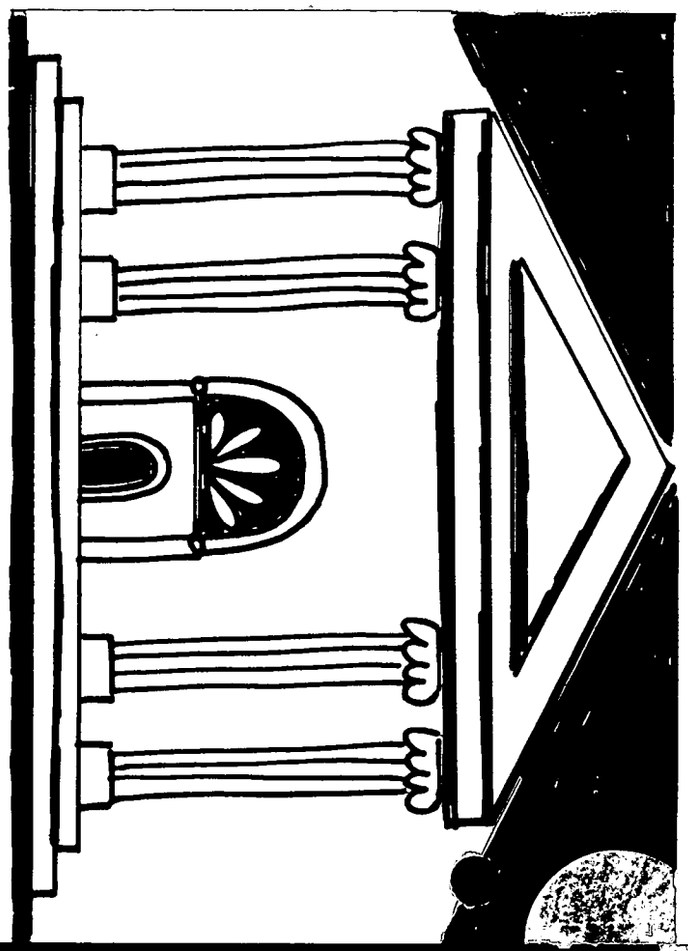


67th Annual Congress on Medical Education



Program Preview

Presented by the Council on Medical Education of the American Medical Association

Included are Programs of

Federation of State Medical Boards of The United States
February 11-14, 1971

Association for Hospital Medical Education
February 12-13, 1971

Council on Medical Education
February 14-15, 1971

Palmer House/Chicago
February 11-15, 1971

ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

Friday Morning, February 12
Contemporary View of Medical Education

Friday Afternoon, February 12
Continuing Medical Education: Planning a Program (A Critical Look at How It's Done)
The Impact of Educational Consultation on Development of Continuing Medical Education Programs in Community Hospitals
Intern-Resident Salary Revisited
The Status of Existing Orientation Program for Foreign Medical Graduates
Educational Programs for Patients
Experiences to Date with Family Practice Residency Programs

Saturday Morning, February 13
Hospital Funding and Medical Education

Saturday Afternoon, February 13
John Leonard Award, Presentation and Address
Annual Business Meeting

THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

Friday Morning, February 12
Legal Counselors of State Medical Boards
Legal Responsibilities in Relation to Allied Health Professions and Medical Assistants
Medical-Legal Status of Paramedical Personnel and Physicians' Assistants
Overview of Medical Aspects in Relation to Allied Health Professions
The Interdependence of Medical and Allied Health Education
View on the Professional Assistant Program and Medical Legal Aspects
State Medical Boards and Statutory Provisions in the Utilization of Professional Assistants
Question and Answer Period

Friday Afternoon, February 12
Allied Health Professions and Paramedical Personnel--Relationship or Responsibility to State Medical Boards
Duke Program for Training and Preparation of Physicians' Assistants
The Nurse as a Physician's Assistant in Pediatrics
Paper by Association of Schools of Allied Health Professions
Study of Nursing and Nursing Education in Regard to Medical Assistants
Question and Answer Period

Friday Evening, February 12
16th Annual Walter L. Bierring Lecture and Dinner

Saturday Morning, February 13
The 1971 Examination Institute
FLEX, The Scientific Method of Examination for Medical Licensure
The FLEXible Way
The Dimensions of the Examination
How to Tell One Figure from Another
The Numbers Game
The "Choice" of Multiple-Choice Test Items
To Choose or Not to Choose: That is the Question
Panel Discussion

Saturday Noon, February 13
Herbert M. Platter Luncheon
Review of a Decade of Federation Activities
Changing Patterns of Medical Education and Curricula
New Philosophies in Medical Education and Their Effect on Recognition of Professional Competence
Impact of Medical Education Changes on Prevailing Licensure Requirements
Can State Medical Boards Keep Pace with Changing Patterns of Medical Education?
Testing for Clinical Competence--Is There a Need for Multiple Examinations?
SAMA Representative Regarding Medical Students' Thoughts on the Examination Process
Question and Answer Period

COUNCIL ON MEDICAL EDUCATION

Sunday Morning, February 14
The Development of New Medical Schools
Do We Really Need More New Medical Schools?
Can New Medical Schools Be Established Faster and Cheaper?
The Location of New Medical Schools: National Design or Local Initiative?
American Citizens in Foreign Medical Schools
American Students at Guadalajara and Bologna
Can We Bring the Guadalajara Student Back Earlier and Still Preserve Educational Standards?

Sunday Afternoon, February 14
The End of the Internship
Does the Internship Belong in Undergraduate or Graduate Medical Education?
Will the Matching Plan Survive as the Internship is Phased Out?
Who Should Accredit the First Year of Graduate Medical Education?
How Can We Provide a Broad Educational Base in the Integrated Residency Program?
Can the Specialty Boards Respond to Change?
The Development of Preliminary Certification Programs in Medicine and Surgery
The Role of the American Board of Medical Specialties
Board Certification or Advanced University Degree?
The Autonomy and Independence of Medical Specialty Boards

Monday Morning, February 15
The Control and Direction of Allied Health Education
The New Commission for the Study of Accreditation of Selected Allied Health Educational Programs
What is the Appropriate Role of the Medical Specialty Society, the University, the Junior College, and the Hospital in the Control and Direction of Allied Health Education?
Increasing the Enrollment of Black and Other Minority Students in Medical School
The Program of the Inter-Association Committee: Progress to Date and Problems Ahead
Can the Current Acceptance Rate for Minority Students be Maintained?
The Development of Financial Support for Full Minority Student Enrollment
Academic Problems in the Enrollment of Minority Students

Monday Afternoon, February 15
Interdependence of American and International Medical Education
Training of Faculties for Medical Schools in Developing Countries
New Models of Education in Developing Countries
Systems of Medical Specialization and World Health Needs
Reciprocal Recognition of Undergraduate and Graduate Medical Education
Improving Physician Distribution Through Medical Education
Pros and Cons of a National Health Service Corps
The Role of the Health Education Center in Medical Education
Use of Student loans and Scholarships as Incentives for Medical Practice

PROGRAM AGENDA

ADVANCE REGISTRATION FORM

Name _____ Degree _____
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Remarks _____

67th Annual Congress on Medical Education

Feb. 11-15, 1971 Palmer House/Chicago

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Parlor and 2 Bedroom Suite			☐ 86 and up
*Studio singles only			☐ 124 and up

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Reservations must be received by the Palmer House by February 1, 1971.