ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 13, 1976

5:00 p.m.	Business Meeting	*Independence Room* *Washington Hilton Hotel*
7:00 p.m.	Cocktails	*Hamilton Room*
8:00 p.m.	Dinner	*Independence Room*

January 14, 1976

8:30 a.m.	Issues Session *(Coffee and Danish)*	*Grant Room*
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon	*Hemisphere Room*
	Executive Council Business Meeting	
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 13, 1976

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS

III. DISCUSSION ITEMS

IV. INFORMATION ITEMS

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*1st Business Session - 5:00 pm - 7:00 pm/January 13
+2nd Business Session - 8:30 am - 12:30 pm/January 14

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

September 17-18, 1975

Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

Jack W. Cole
Chairman (Presiding)
Robert M. Berne
F. Marion Bishop
A. Jay Bollet
Ronald W. Estabrook
Rolla B. Hill
Thomas K. Oliver, Jr.
Robert G. Petersdorf*
Leslie T. Webster

Staff

Mary H. Littlemeyer
Thomas E. Morgan
Mignon Sample
John F. Sherman
August G. Swanson
Emanuel Suter

ABSENT: Carmine D. Clemente

Continuing the procedure adopted at its April meeting, when the CAS Administrative Board agreed to hold its business meeting the evening before the regularly scheduled meeting, the Board convened at 5:00 p.m. on September 17.

I. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of June 18-19, 1975, were adopted as circulated.

II. Action Items

A. Ratification of LCME Accreditation Decisions

ACTION: The CAS Administrative Board accepted the accreditation recommendations (as set forth in the Executive Council Agenda on pages 20-22).

B. LCME Procedures for Levying Charges to Schools for Early Stage Accreditation Site Visits and Provisional Accreditation

ACTION: The CAS Administrative Board approved the recommendation (as set forth in the Executive Council Agenda on page 23) that the Executive Council endorse the principle of the LCME levying charges for a Letter of Reasonable Assurance site visits to developing medical schools.

*Ex Officio

C. LCME Voting Representation of the Canadian Medical Schools

The function and membership of the LCME were reviewed. The primary thrust of the LCME is accreditation of undergraduate medical colleges in the United States and Canada. The LCME consists of 12 members: five each representing the AAMC and the AMA and one federal member and one public member. There is no representation from the Canadian sector, although at this time 16 Canadian medical schools are accredited by the LCME. The feeling of the CAS Board was that such representation was entirely appropriate and long overdue.

ACTION: The CAS Administrative Board approved the recommendation (as set forth in the Executive Council Agenda on page 24) that the Executive Council endorse the seating of a voting representative of the Association of Canadian Medical Colleges on the LCME.

D. Election of Institutional Members

ACTION: The CAS Administrative Board approved the recommendation (as set forth in the Executive Council Agenda on page 25) regarding election to Institutional Membership in the AAMC of the University of South Florida College of Medicine and Southern Illinois University School of Medicine.

E. Applications for Membership

ACTION: The CAS Administrative Board approved for recommendation to the full Council the applications for membership of the Association of Medical School Departments of Biochemistry and the American Society of Hematology. NOTE: The Board had previously approved for CAS membership applications of the Society of Gynecologic Investigation, American Society of Plastic and Reconstructive Surgeons, and American College of Obstetricians & Gynecologists (for reinstatement of membership).

ACTION: The CAS Administrative Board recommends to the AAMC Executive Council the above named societies for AAMC membership pending approval by the full Council of the CAS and subsequent approval by the AAMC Assembly.

F. Election of Individual Members

The criteria for and benefits to individual membership were delineated. Anyone who is interested in medical education may apply for individual membership. They have no power in the governance structure of the Association. Their membership includes subscriptions to the Journal of Medical Education and the President's Weekly Activities Report.

Dr. Swanson reported that one individual whose application for membership was currently before the Executive Council for consideration was using his membership status on his letterhead in a way which was misleading to the extent that institutional membership would be implied. This was in connection with a venture to provide M.D. degrees to those with other advanced degrees by correspondence courses. This individual is being denied membership.

Members of the Board reiterated their concern that so many categories of AAMC membership exist that it is confusing and misleading. (See Minutes, CAS Administrative Board meeting June 19, 1975, Paragraph II.H, pp. 4-5 for action in this regard). Dr. Swanson reminded the Board that any revision in memberships would require an AAMC Bylaw change.

ACTION: The CAS Administrative Board approved the recommendation regarding the election of Individual Members (as listed in the Executive Council Agenda on pages 28-30), excluding the individual cited above.

G. Election of Emeritus Members

Emeritus Membership in AAMC is open to individuals who have been active in AAMC affairs prior to retirement. Emeritus Members receive the same AAMC publications as do Individual Members, but the former pay no dues. Unlike AAMC Distinguished Service Members, Emeritus Members must have reached retirement. A total of nine individuals were nominated for Emeritus Membership this year. Of these, six were felt to have met the established criteria for eligibility.

ACTION: The CAS Administrative Board approved the recommendations for election to Emeritus Membership of the individuals listed in the Executive Council Agenda on page 31 and disapproved those listed on page 32.

H. Amendment of the AAMC Bylaws to Establish a Category of Corresponding Members

The previous action of the AAMC Executive Council on this matter (not approved by the CAS Administrative Board as stated--see CAS Administrative Board Minutes June 18, 1975, Paragraph II-H, pp. 4-5) was detailed on page 33 of the Executive Council Agenda. The basic concern of the CAS Administrative Board--that it is increasingly difficult, if not impossible, to differentiate among the several classifications of AAMC memberships those that connote a membership by virtue of accreditation based on standards, etc. In other words, for $25.00, one can become an Individual Member, receive the AAMC's important publications (and, added Dr. Cole enjoy a "longer obituary") without meeting any criteria. This, and the proposed "Corresponding Member," the Board insisted would better be called some kind of Subscribers. Dr. Swanson pointed out that Individual Memberships were

established in the Association in 1953. As earlier stated the CAS Administrative Board felt it could not take action to establish the new category known as Corresponding Members.

ACTION: The CAS Administrative Board disapproved the recommendation in the Executive Council Agenda on page 33 that would have established a new classification of AAMC members known as Corresponding Members. Additionally, the CAS Administrative Board voted to recommend to the Executive Council that a moratorium be declared on AAMC membership categories until the entire membership structure can undergo a thorough review.

I. Flexner and Borden Award Nominees

Few nominations were received for the AAMC Awards. Results from promotion among the CAS member societies were disappointing. One suggestion was to write to the CAS societies after the Annual Meeting, advising them of the Borden Award results, and asking for their nominations for next year's competition. This lead-time will enable the societies to get this item on their agendas for action. Another suggestion was for promotion through CAS Briefs.

ACTION: The CAS Administrative Board approved the recommendations of the Flexner and Borden Award Committees as contained on page 34 of the Executive Council Agenda.

J. The Role of the Foreign Medical Graduate

The CAS Administrative Board reviewed the Executive Council's reaction to the Report of the Coordinating Council on Medical Education: Physician Manpower and Distribution--The Role of the Foreign Medical Graduate (Executive Council Agenda page 40) and the Report itself (Executive Council Agenda pp. 41-66). The two items which received the most criticism were the recommendation for the development of remedial programs for resident FMGs who have failed to qualify for ECFMG certification or licensure and the recommendation that the Fifth Pathway be utilized as a mechanism for entry of U.S. citizens studying medicine abroad. It was also stressed that the State Department should not overcommit United States medical institutions in an attempt to reach agreements with other countries trying to train physician manpower. Ultimately, the final decision in the United States for the initiation of an exchange program must rest with the American institution.

The appropriateness of specific recommendations regarding training requirements for licensure of both U.S. and foreign medical graduates was questioned because they are not germane to this document and because the CCME does not have authority or power of enforcement.

ACTION: The CAS Administrative Board approved the recommendation that:

1. The Executive Council approve the report on the Role of the Foreign Medical Graduate of the Coordinating Council on Medical Education with specific exceptions as follows:

   -Recommendation B-11, a and b, page 14, lines 31-46 referring to the initiation of remedial programs for hitherto unqualified resident FMGs;

   -Recommendation C-6, page 16, lines 33-40 referring to the "Fifth Pathway."

2. The letter of conveyance to the CCME of the Council's decision include the above comments.

It was noted (page 15) that in discussing U.S. nationals the word "American" was used in the final paragraph, and it was suggested that in future drafts this should be revised.

K. Report of the National Health Insurance Review Committee

At its April meeting, the Executive Council requested that the Chairman appoint a small Review Committee to recommend appropriate action on a national health insurance policy statement which had been forwarded for consideration by the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education. The Committee was also requested to recommend appropriate additions or modifications to the existing AAMC National Health Insurance Policy in accord with the recommendations to the CCME/LCGME. An oral Committee Report was presented at the June Executive Council meeting by David Thompson, M.D. After brief discussion, the Executive Council voted to table the Committee Report until its September meeting so that a written report could be formally included in the meeting agenda. A summary of the recommendations of the CCME/LCGME Committee on National Health Insurance and Financing Medical Education presented to the CCME on March 10, 1975 was included in the Agenda along with reactions of the Review Committee to the recommendations, and recommendations for modification of the CCME/LCGME recommendations.

ACTION: The CAS Administrative Board approved the Committee Report as presented on pages 71-74 in the Executive Council Agenda.

L. Recognition of New Specialty Boards

Dr. Cole read the statement (Executive Council Agenda page 77) that was proposed as a position of the AAMC Executive Council to go forward to the CCME and its member organizations. The final sentence, Dr. Petersdorf pointed out, was not only confusing but in error. It read, "The Coordinating Council, in conjunction with the Liaison Committee on Graduate Medical Education, should establish specifications and procedures for the authorization of the development of

new specialties certifying boards and residency accreditation programs." One function, that of the certifying boards, is to certify individuals; the other, residency accreditation, is to accredit programs. It was felt that the deletion of this sentence would clarify the statement. The following action was therefore taken:

ACTION: With regard to this action, the CAS Administrative Board accepted the first sentence of the recommendation on page 77 of the Executive Council Agenda with the addition of the word "ultimate" and the deletion of the last sentence. The statement adopted reads:

"The Executive Council of the Association of American Medical Colleges believes that the authorization of the formation of new specialty boards and the development of accreditation programs for new specialties must be the ultimate responsibility of the Coordinating Council on Medical Education and its parent organizations. ~~The Coordinating Council, in conjunction with the Liaison Committee on Graduate Medical Education, should establish specifications and procedures for the authorization of the development of new specialties certifying boards and residency accreditation programs.~~"

M. Modification of "Recommendations of the AAMC Concerning Medical School Acceptance Procedures"

ACTION: The CAS Administrative Board approved the recommendation of the GSA Steering Committee that appeared on page 78 of the Executive Council Agenda.

Mc. Proposed Recommendations of the AAMC Concerning the College Level Examination Program

ACTION: The CAS Administrative Board approved the recommendations of the GSA Steering Committee that appeared in the Executive Council Agenda on page 80.

N. The Response of the Association of American Medical Colleges to the Principal Recommendations of the Goals and Priorities Committee Report to the National Board of Medical Examiners

This item, which appeared in the Executive Council Agenda (pages 81-83) contained the substance of recommendations adopted by the Council of Academic Societies at its Fall 1974 meeting. It was to be presented to the Assembly for adoption, assuming its passage by the Executive Council in September. Since in essence nothing new was contained in the response, it was agreed that this topic would be appropriate as an information item for the full meeting of the Council.

ACTION: The CAS Administrative Board approved the recommendations set forth in the Executive Council Agenda on pages 82-83.

O. Planning Agency Review of Federal Funds Under the Public Health Service Act Titles IV and VII

The CAS Administrative Board reviewed the views of the AAMC concerning the Health Systems Agency and Statewide Health Coordinating Council review of proposed uses of Federal funds under P.L. 93-641. This document was prepared by an AAMC Task Force whose membership was listed on page 85. Due to the timeliness of the issue and the need for AAMC input to be received during the preliminary regulation development process, the paper was submitted to the Director of the HEW Bureau of Health Planning and Resources Development on August 25. In the transmittal letter (Executive Council Agenda pp. 86-87), the Association's recommendations were summarized.

ACTION: The CAS Administrative Board approved the Report of the Task Force on Implementation of Health Planning Legislation as set forth in the Executive Council Agenda.

P. Recovery of Medicaid Funds and Soverign Immunity

ACTION: The CAS Administrative Board considered the information on page 92 of the Executive Council Agenda and decided to take no action on the recommendation.

Q. U. S. Citizens Studying Medicine Abroad

The present situation involving U. S. citizens studying medicine abroad was delineated in the Executive Council Agenda. It was characterized as "nearly chaotic and having a disruptive effect on established procedures of accreditation and licensure." The Association's options in response to this dilemma were outlined, and recommendations were given on page 97.

ACTION: After reviewing the material on this topic as set forth in the Executive Council Agenda on pages 93-100, the CAS Administrative Board voted to approve the recommendation on page 97 with the exception of the final clause on the next to last line. The clause deleted was "and COTRANS should be phased out on a compatible schedule."

The CAS Administrative Board indicated that it would be interested to see a review of COTRANS activity in the agenda for the next Administrative Board meeting.

R. Appointments to the LCME Appeals Panel

ACTION: Noting the preponderance of Deans Emeriti comprising the list of members approved by the LCME appeals panel, the Cas Administrative Board indicated they will forward to Dr. Schofield names of younger individuals who are engaged in teaching or otherwise active in academic medicine.

S. CAS Brief

ACTION: The CAS Administrative Board endorsed the new format of the CAS Brief as well as the content for the September issue.

T. Annual Meeting

ACTION: The CAS Administrative Board reviewed the AAMC Annual Meeting Schedule and decided:

1. To invite the Presidents (or an Official Representative as a designee) to attend a breakfast with the CAS Administrative Board on Tuesday, November 4.

2. To plan a lunch on the day of the CAS meeting, November 4.

3. To promote the November 4 session, in particular as open discussion on major topics will be featured instead of special presentations in earlier years.

U. CAS Nominating Committee Report

ACTION: The CAS Administrative Board approved the slate endorsed on September 12 by the newly constituted Nominating Committee.

III. Discussion Items

A. National Intern and Resident Matching Plan

The CAS Administrative Board agreed that a report on the status of the matching plan should be on the agenda for the fall meeting.

B. Delphoid Survey

The response of faculty to the academic medical center problem identification survey was felt to be good considering the fact that a short turn-around time was involved and the survey took place during the summer. No additional information with regard to next steps of the survey was available.

C. Study of Impact of Research Funding on Academic Medical Centers

The status of this study was reported on page 37 of the CAS Agenda. Dr. Morgan heads this effort.

D. Issues Session*

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*The Board's business meeting was adjourned at 7:30 p.m. and was followed by cocktails and dinner. The issues session was convened on September 18 at 9:00 a.m. This session focused on the topics identified at the last meeting, Research Training and Continuing Education, for which discussion papers had been drafted.

1. Research Training

Discussion on this issue was led by Dr. Webster. The CAS Administrative Board agreed that:

1. The feasibility of the accreditation of research training programs should be explored;

2. Multidisciplinary programs should be supported as a means to training more broadly capable scientists; and

3. The AAMC should work with other organizations such as the NAS, NIH, etc. to achieve long-term solutions to the research manpower problem and its support.

2. Continuing Education

Mr. Harrison Owen of the National Heart & Lung Institute joined the Board for this discussion which was led by Dr. Bollet. The CAS Administrative Board agreed that:

1. AAMC should work toward developing alternatives to relicensure based solely on continuing medical education credits;

2. AAMC should assess opportunities and problems which moves toward mandated continuing medical education will place before medical schools and faculties; and

3. AAMC should work with the major voluntary agencies in accomplishing (1) and (2).

E. Adjournment

The formal meeting was adjourned at 12:30 p.m. in time for a joint luncheon with the Administrative Boards of the other two councils. The business meeting of the Executive Council followed.

MHL:mf
11/19/75

UNIVERSITY OF CALIFORNIA, LOS ANGELES

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DEPARTMENT OF ANATOMY
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

December 22, 1975

Dr. August G. Swanson
Association of American Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Gus:

I am sorry to say that in my inquiries here, I have not been encouraged in recommending the American Association of Gynecological Laparoscopy for admission to the Council of Academic Societies. I think the principal reason is that the objectives of the group are not really academic but primarily technical.

The usual response from our gynecologists here was a knowing laugh and terms such as "a group that plays into the hands of drug and instrument companies", "hucksters, big advertisers", "not a scientific group at all, not academic".

Although they list a number of fairly well known academic Ob and Gyn specialists among their participants in their First International Congress, that program was long on technique and short on academics.

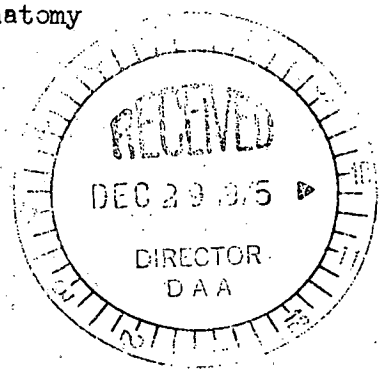
I think a discussion among the Council's Board will be necessary but as of now, I am leaning toward the negative.

Sincerely yours,

Carmine

Carmine D. Clemente
Professor of Anatomy

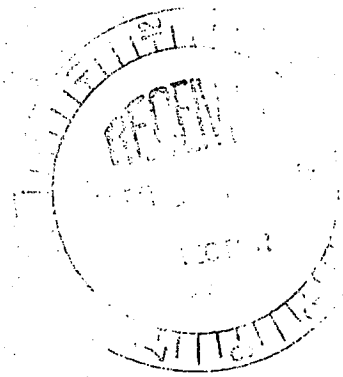
CDC:lc



University of Pittsburgh

SCHOOL OF MEDICINE
Department of Pediatrics
Office of the Chairman

December 3, 1975



August G. Swanson, M.D.
Director of Academic Affairs
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Gus:

I have reviewed the materials you have sent me regarding the American Association of Gynecologic Laparoscopists and I must conclude that they are a mechanical/technical not an academic organization. Membership is broad and requires no special skills or training beyond the M.D. degree. "To be eligible as a member .....an applicant must be a physician and possess an interest in gynecologic endoscopy."

The program of the 2nd International Congress of Gynecologic Endoscopy was almost entirely technical on the order of "what I have seen or what I can do through a laparoscope". There was almost no evidence of thoughtful investigation.

Obviously the matter should be reviewed by the Administrative Board but I will present a negative view. Put simply, there is no evidence that this organization is an Academic Society.

Cordially,

Thomas K. Oliver, Jr., M.D.

TKO:hl

cc: Dr. Carmine Clemente

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: American Association of Gynecologic Laparoscopists

MAILING ADDRESS:
11239 So. Lakewood Blvd.
Downey, California 90241

PURPOSE:

1. Teach
2. Demonstrate
3. Instruct
4. Exchange Ideas
5. Distribute Literature
6. Hold Meetings, Seminars, and Conferences
7. Stimulte interest in gynecological laparoscopy
8. Maintain and Improve Medical Standards in Medical Schools and Hospitals regarding Gynecological Laparoscopy.
9. Maintain and Improve the Ethics, Practice, and Efficiency of the Medical Practice Pertaining to Obstetrics and Laparoscopy
10. ~~MEMBERSHIP CRITERIA:~~
10. Improve Medical Surgical Techniques in the Area of Family Planning, As Well As Providing Information and Knowledge to All Governmental Agencies
11. Conduct Medical Research in the Area of Gynecological Laparoscopy and to Publish Medical and Scientific Literature pertaining to such fields.

NUMBER OF MEMBERS: MEMBERSHIP CRITERIA: PLEASE SEE ATTACHED
2,072 members
NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED:
June 27, 1972
SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Updated as of 1-6-74 1. Constitution & Bylaws

1972, 1973, 1974, 1975 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

AAGL MEMBERSHIP CRITERIA

Regular Membership: To be eligible to become a regular member of the Association, an applicant must be a physician and possess an interest in gynecologic endoscopy.

Associate Membership: To be eligible to become an associate member of the Association, an applicant need not be a physician but must satisfy the Membership Committee that he is interested in the field of gynecologic endoscopy.

Honorary Membership: Honorary members shall be elected by a vote of the Board of Trustees.

Founding Membership: Founding members shall be elected by a vote of the Board of Trustees.

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

X YES _____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

509 (a) (2)

3. If request for exemption has been made, what is its current status?

X a. Approved by IRS

___ b. Denied by IRS

___ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Jordan M. Phillips, M.D., F.A.C.O.G.
President

(Completed by - please sign)

October 9, 1975
(Date)

POSITION PAPER OF
NATIONAL ADVISORY COUNCIL ON
GERIATRIC MEDICAL PROGRAMS

From time to time we receive position papers of this type from various organizations and councils urging that the area of their particular concern be expanded in the curricula of the medical schools. Our usual response is that we do not make it a policy to direct the medical schools in their curriculum development. More recently, we have recommended to some agencies that they develop a set of goals and objectives for education in their particular area of special interest and circulate these to concerned institutions and agencies. Further advice and guidance from the Administrative Board is sought regarding how to respond in general to requests of this type.

POSITION PAPER
NATIONAL ADVISORY COUNCIL ON
GERIATRIC MEDICAL PROGRAMS

By the end of this century there will be over 25 million people in the United States over the age of 64. Many of these will have multiple and complex interacting illnesses that require much more care per capita than younger patients. This care requires expertly trained physicians.

At the present time the medical input to a good part of the geriatric institutions in this country is quantitatively as well as qualitatively inadequate. This is not to say that there is not involvement by competent and interested physicians, but it is not an overstatement to say it is rarely sufficient.

It is generally acknowledged that the medical care of older people in this country leaves much to be desired. Geriatric medicine is, to a large extent, a neglected area of medical education and allied health professional training.

Geriatric medicine has not received the stature it should have in this country's medical training programs. Understandably this makes it exceedingly difficult to attract physicians in training to work in this area.

Actually geriatric medicine provides an excellent opportunity for the in-depth study of human disease and for the training of physicians and allied health care personnel.

Steps to provide solutions to the inadequacy of geriatric medical care are urgently needed. Attention should be directed to developing high caliber programs in geriatric medicine that will serve as models of excellence. These programs should be of such caliber as to attract a significant body of medical students, young physicians, and allied health personnel.

Excellence in geriatric medicine, like any other clinical discipline, must rest on a solid scientific foundation. It is essential that training programs in geriatric medicine include fundamental research in the problems of the aged as well as in the process of aging.

A National Institute on Aging has recently been established within the National Institutes of Health. The time is opportune to support the development of programs in geriatric medicine in the medical institutions of this country.

PROPOSAL

The National Advisory Council on geriatric medical programs encourages the medical schools in the United States to establish interdisciplinary programs in geriatric medicine. These programs should serve as the basis for geriatric educational experience at all levels of education and training for physicians and allied health care professionals.

REPORT OF JOINT TASK FORCE ON MANPOWER IN PATHOLOGY

Increasingly, manpower studies are being undertaken by a variety of professional organizations and specialty societies. This report from the Task Force on Manpower in Pathology is an example. At the present time, the American Board of Internal Medicine, the American College of Physicians, the American Society of Internal Medicine, and the Association of Chairmen of Departments of Medicine are planning a major survey of manpower in Internal Medicine and its subspecialties. The staff has been in touch with Al Tarlov, who is leading the study, and cooperation is assured. It is the belief of the staff that because the Association and its constituents have prime responsibility for the education of physician manpower and biomedical research manpower, we should have a prime objective to assist in the coordination of manpower studies. The advice of the Board and any information regarding other manpower studies now in progress or being contemplated is sought.

REPORT OF JOINT TASK FORCE ON MANPOWER IN PATHOLOGY, CAP- ASCP

Joint Report to the Board of Directors of ASCP and the Board of Governors of CAP

I. Introduction

The Task Force has completed its mission of conducting a survey of fact and opinion regarding manpower problems and needs in Pathology in the United States. The survey was conducted by means of a set of questionnaires developed in collaboration with our consultants, Lawrence and Leiter, Management Consultants, Kansas City, Mo. Questionnaires were sent to all pathologists in practice in the United States (approximately 9000 individuals); 2546 questionnaires were sent to residents and interns in pathology; 220 questionnaires were sent to training directors. Copies of these three questionnaires (to pathologists in group or solo practice, to residents and to training directors) are appended to this report.

The response from pathologists was outstanding. 1927 questionnaires were returned completed representing approximately 6696 of the approximately 9000 practicing pathologists or close to a 75% response. (Pathologists were instructed to see that only one questionnaire was returned from each group). Of the 8300 board certified pathologists, the survey accounted for 6222, again, approximately 75%. 952 residents responded for a total of 37%, considered an excellent response. The response from training directors was also a respectable 40%, though it represented only 670 training positions or 26% of the AMA approved residency positions. It is unlikely, however, that all of the approved residency positions are filled so the percentage of active residency positions accounted for is probably considerably higher than this figure. All in all, the response from pathologists, residents and training directors was outstanding and permits a very accurate and penetrating analysis of current manpower needs in pathology.

Mr. David Bywaters designed the questionnaire under the direction of the Task Force. He also conducted the analysis of the results obtained and compiled the report from Lawrence - Leiter. Dr. James Bridgens acted as Consultant to Lawrence - Leiter, in all stages of the survey and his advice and guidance has been invaluable.

II. SUMMARY OF REPORT OF SURVEY

All members of the Board of Directors of the ASCP and of the Board of Governors of the CAP will receive copies of the Lawrence - Leiter Report on the survey directly from the CAP office. The following is a summary of the report, including some preliminary conclusions which the Task Force drew from it.

A. Pathologists in Practice

There are 8929 pathologists in solo or group practice in the United States. More than 90% of these are board certified (8300 at the end of 1973). Of the 6143 fulltime pathologists accounted for in this survey, 4036 or approximately 67% are practicing in a single general community hospital of a range between 200 and 700 beds (non-medical school, non-government). Of those that are board certified (6222, which includes fulltime and part-time practioners), 4568 or approximately 73% are certified in both AP and CP. The largest age group are those between 35 and 44 years of age (2553) or 41% of the total.

During each of the past five years, between 500 and 700 residents have completed their training and attained board eligible status. 43% of these residents are foreign medical graduates and 80% of the latter have stayed to practice in the United States. During this same period, 440 pathologists have left practice through death, retirement or career change. The net addition over this period is approximately 1800 pathologists, a figure which matches the figure of 1800 derived from the AMA listing, a confirmation of the validity of this survey.

B. Demand for Pathologists

The survey indicates that 22% of pathology practices are currently seeking a pathologist to fill a funded position. This represents a total of 534 full-time positions in those practices from which responses were obtained or a total of approximately 700 funded vacancies if this figure is projected over all pathology practices. The largest percentage of vacancies are in cities between 25,000 and 250,000 in size (45%), a desirable community size from the viewpoint of the residents (40% preferred practice in such communities). The vacancies are well distributed throughout the country with the Gulf and Great Lakes regions having the greatest numbers.

The projected needs over the next five years for pathologists, taking into account losses from practice, are 2700 (or 2160 in the next four years). Most of this are needed to meet expanded patient loads (985 or 35%). Since it is anticipated that approximately 650 will leave practice, the net addition to the practice of pathology is seen as 2000.

These figures are consistent with the experience of the past five years. The net addition of pathologists in practice, both from our survey and the AMA listing, was 1800 pathologists. Apparently, this trend is expected by pathologists to continue over the next five and even the next 10 years.

C. Supply of Pathologists

There appears to be 2153 residents in the training "pipe-line". About 76% of residency "slots" are occupied. 83% of the residents are male; 48% are foreign medical graduates. Presuming that all of these 2153 residents enter pathology practice in the United States, they will make an almost ideal match with the 2160 vacancies anticipated in the next four years (see section B above). It is unlikely, however, that all will enter practice: only 81% of the foreign medical graduates indicate that they intend to enter practice in this country. Some who attain board eligibility will not succeed in becoming board certified and there will be other losses through change in career objectives. If the projections of this survey are to be accepted, therefore it is likely that there will continue to be a modest deficit in pathologists five years from now.

Fifty percent of the residents plan to practice community hospital pathology and 37% of these seek to practice in a large community hospital where they can share responsibility and skills with other pathologists. Twenty percent indicate they would like to work at a medical school or University Hospital. Most training directors (80%) see their programs as primarily preparing pathologists for community hospital practice. These figures match well with demand since more than 50% of vacancies are in community hospitals.

D. Matching Supply and Demand

Though in numbers, demand for pathologists and supply from residency programs seem to match well, considerable evidence of lack of matching emerged from the survey. Sixty-seven percent of practices with vacancies have had applications to fill them and 33% have had no applications. 1,233 applications have been rejected for 687 positions. 401 offers for these same vacancies have been rejected by candidates. Personal contact and recommendations is the major mechanism of recruitment (60%). The College Placement Bureau runs a poor second with 17% of those filling vacancies using this avenue.

It appears to us from the survey that pathologists are now quite selective in filling vacancies in their practice group. Requirements for successful candidates have increased and will continue to rise.

E. Opinions Concerning Factors Involved in Manpower Needs In Pathology

Respondents were asked to weigh the effects of various changes in the practice of pathology on manpower needs. A refreshing diversity of opinion exists. It was interesting for us to note, however, that there was a considerable amount of agreement between practicing pathologists and training directors in the opinion poll. On only one topic, however, was there really strong agreement between both groups. Both disagreed strongly with the statement: "We could get by with fewer pathologists here".

A decided majority of both groups agreed with the following statements: "Automation will not reduce need for pathologists"; "There is a need to subspecialize in pathology"; "There is a need for better trained pathologists"; "We need more forensic pathologists".

Lack of agreement was notable with respect to the effects on manpower needs of: regionalization, consolidation of laboratories, use of pathologist assistants; advent of national health insurance and advent of professional service review organizations (PSRO).

F. Plans

The Joint Task Force on Manpower plans to make known the results of this survey in the following ways:

1. A "scientific" paper will be published which will include certain key data and key summarizing conclusions. It will probably be submitted to the American Journal of Clinical Pathology for publication. A preliminary draft is expected to be ready by August 8. The writing committee is composed of the following members of the Task Force: John B. Henry (Chairman), Marjorie Williams, A. Wendell Musser, W. J. Reals, and E. S. Benson. All members of the Task Force and its two consultants (Mr. Bywaters and Dr. Bridgins) will be included as authors.

2. A "monograph" will be prepared which will include the edited full Lawrence - Leiter report of the survey. It will include also an introduction and summary by the Task Force and will have covers with the logi of the two sponsoring societies. It will be available for sale at cost. The writing committee will include: Ray Cowan (Chairman), Mannie Bergnes, Steven Nelson and James J. Humes.

G. Conclusions

The survey indicates that there is a present need for additional pathologists and that this need will continue over at least the next five

years. The projected demand is slightly greater than the supply of residents in the "pipe line". It does not appear likely at this point that there will be an excess of pathologists within the next five years.

For the Joint Task Force:

William J. Reals, Co-Chairman (CAP)
Ellis S. Benson, Co-Chairman (ASCP)

CAS SPRING MEETING

TENTATIVE CAS PROGRAM OUTLINE

March 16, 1976

9:00 - 10:30	Business Meeting
10:30 - 11:00	Coffee Break
11:00 - 12:00	Information from Biomedical Research Panel Report Thomas E. Morgan
12:00 - 2:00	Lunch/Guest Speaker Donald Frederickson
2:00 - 3:30	Panel of Three Chairmen -Alternatives to Training Grants -Possibilities of Centers -Picking up other Responsibilities, e.g. teaching - service
3:30 - 4:30	Coffee Break
4:00 - 5:30	Panel of Three or Four - Ivan Bennett Presiding -Possibilities of Change in the Future (Future = 1976-1980)
5:30	Adjourn

IMPACT STUDY FOR THE PRESIDENT'S BIOMEDICAL RESEARCH PANEL

Tom Morgan has now completed the first draft of his study on the impact of research funding on the medical schools. An oral presentation of the study will be made before the President's Biomedical Research Panel on January 29. A brief presentation of the study will be made to the Board for comment and criticism.

COTRANS DATAGRAM

At the CAS Meeting of September 17 information was requested regarding the COTRANS program operated by the Association. Because the Coordinating Council on Medical Education has asked that the Association review its position regarding the Fifth Pathway, the following datagram is provided. COTRANS has been a growing program and in the future can facilitate the transfer of qualified students back to American medical schools.

DATAGRAM

COTRANS: After Five Years

During the five-year period from its inception in 1970 through 1974, the Coordinated Transfer Application System (COTRANS)* has sponsored nearly 4,000 U.S. citizen applicants from foreign medical schools for Part I of the National Board of Medical Examiners (NBME) tests. More than 3,000 of these took Part I of the NBME examinations, about one-third passed, and over 800 were admitted with advanced standing by U.S. medical schools (Tables 1 and 2).

The steady upward increase of approved applicants from less than 300 in 1970 to more than 1,100 in 1974 was paralleled by the number of examinees but not by the yearly totals of advanced standing admissions. In the first three years, nearly all COTRANS-sponsored examinees who passed Part I of the NBME examinations were admitted by U.S. medical schools, mostly as second- or third-year students; but in 1973, only about one-half of the passing COTRANS group was accepted (1). (Precise annual admission percentages cannot be established because COTRANS-sponsored students who were accepted include some examinees who passed Part I of the NBME tests the preceding year and some who performed well in anatomy, biochemistry, and physiology but did not achieve passing total scores.) In the fall of 1974, similar upper class admissions improved when about two-thirds of the passing COTRANS group succeeded in transferring from foreign to U.S. medical schools.

COTRANS Applicants

Of the 3,844 students sponsored by COTRANS to take Part I of the NBME tests in the five years under review, 1,126 (29 percent)—the largest group in the history of the program—were approved as eligible in 1974. Approval was based on written evidence of (*a*) current enrollment in a foreign medical school listed by the World Health Organization, (*b*) passing of at least three specified basic medical science courses, and (*c*) U.S. citizenship. Approval, however, applies only to sponsorship for Part I of the NBME examinations and does not include any matching or placement services.

Applicant profiles of basic data were provided to 44 participating U.S. medical schools (and to other schools upon request) in periodic COTRANS Eligibility Summaries, prior to the June and September 1974 Part I of the NBME tests. These summaries listed name, address, Social Security number, age, state residence, undergraduate school, undergraduate grade point average, foreign medical school attended, and Medical College Admission Test (MCAT) scores.

Characteristics of Examinees

The state residence pattern of previous years continued in 1974. More than one-half, or 475 (59 percent), of the COTRANS-sponsored examinees listed New York, California, and New Jersey as their permanent state of residence. Illinois, Texas, Florida, Pennsylvania, and Ohio were reported as home states by 181 (22 percent), while 132 (16 percent) were from Massachusetts, Connecticut, and Colorado. Twenty-one examinees were from Puerto Rico; 29 states supplied fewer than 10 each.

Ages of 1974 examinees ranged from 21 to 55 with a mean age of 25, the same mean as in 1973. Neither was there any change in the proportion of U.S. women examinees from foreign medical schools; they continued to account for 5 percent of the total.

A comparison of mean undergraduate grade-point averages of passing and failing

*The Coordinated Transfer Application System, a cooperative effort of the Association of American Medical Colleges and the National Board of Medical Examiners, is designed to assist the U.S. citizen who is studying medicine abroad and who wishes to transfer from the foreign medical school to advanced standing in a medical school in this country.

examinees in 1974 yielded no differences. Both had a mean grade-point average of 2.71, representing a slight increase over the 2.35 average of the previous year. Mean MCAT Science scores, however, showed a difference of 48 points between the 540 of the passing group and the 492 of those who failed. The mean MCAT Science scores of all applicants to the 1972–73 entering class (the class for which most of the 1974 COTRANS group would have applied originally) were 575 for acceptees and 524 for those who were not accepted.

TABLE 1

SUMMARY OF APPLICATION AND NBME PART I TESTING ACTIVITY OF COTRANS-SPONSORED EXAMINEES, 1970 THROUGH 1974

Year	No. Applicants Sponsored	Number Tested	Number Passed	Percent Passed
1970	285	270	77	28.5
1971	580	437	102	23.3
1972	807	676	215	31.8
1973	1,046	957	292	30.5
1974	1,126	810	358	44.2
Total	3,844	3,150	1,044	33.1

NBME Test Performance

The highest pass rate since 1970 on Part I of the NBME tests—44 percent—was achieved by 358 of the 1974 COTRANS-sponsored examinees. Thus, the overall pass rate for all years combined was raised above 30 percent for the first time (Table 1). This improvement may be attributed to the composition of the 1974 group that consisted of 56 percent first-time and 44 percent repeat examinees, as

TABLE 2

SUMMARY OF ADMISSIONS OF COTRANS-SPONSORED EXAMINEES, 1970 THROUGH 1974

Test Year	No. Participating Schools	Admission Year of Accepted COTRANS Applicants			Total per Year
		2nd Year	3rd Year	4th Year	
1970	35	12	70	0	82
1971	46	25	90	0	115
1972	46	36	167	11	214
1973	49	34	115	4	153
1974	44	85	169	8	262
Total	—	192	611	23	826

Source: AAMC Fall Enrollment Questionnaires.

TABLE 3

NBME PART I TEST PERFORMANCE OF 1974 COTRANS-SPONSORED EXAMINEES BY LENGTH OF FOREIGN MEDICAL EDUCATION

Country	Year 1		Year 2		Year 3		Year 4		Year 5–7	
	No. Exam	No. Pass	No. Exam	No. Pass	No. Exam	No. Pass	No. Exam	No. Pass	No. Exam	No. Pass
Mexico	142	44	406	179	55	28	5	1	0	0
Italy	1	1	12	5	23	15	13	10	0	0
Belgium	3	1	11	8	21	13	9	7	2	2
Philippines	10	0	17	13	0	0	0	0	0	0
Spain	1	0	1	0	2	1	14	3	3	2
Switzerland	0	0	4	3	11	10	0	0	2	2
France	4	0	5	2	4	1	2	1	0	0
Other*	5	0	10	0	11	6	1	0	0	0
Total	166	46	466	210	127	74	44	22	7	6
Percent	20†	28‡	58†	45‡	16†	58‡	5†	50‡	1†	86‡

* Includes: Austria (1), Costa Rica (1), Chile (1), Dominican Republic (7), Greece (3), Guatemala (1), Hungary (2), Ireland (5), Iran (3), Jamaica (1), Korea (1), Scotland (1).

† Percent of total number examined.

‡ Percent passed of number examined, by length of foreign medical education.

TABLE 4

PERFORMANCE OF COTRANS-SPONSORED EXAMINEES ON PART I OF 1974 NBME EXAMINATIONS

Country of Medical School Ranked by No. of Examinees			Passed 1974 NBME Test Part I		
Country	No.	Percent of Total Examinees	No.	Percent per Country	Country Ranked by Pass Rate
Mexico	608	75	252	41	5
Italy	49	6	31	63	3
Belgium	46	6	31	67	2
Philippines	27	3	13	48	4
Spain	21	3	6	29	6
Switzerland	17	2	15	88	1
France	15	2	4	27	7
Other*	27	3	6	22	--
Total	810	100	358†	44	

* Includes: Austria (1), Costa Rica (1), Chile (1), Dominican Republic (7), Ireland (5), Greece (3), Guatemala (1), Hungary (2), Iran (3), Jamaica (1), Korea (1), Scotland (1).

† 190 (53 percent) of passing examinees were test repeaters.

compared with only 29 percent repeaters in 1973. Of those who passed in 1974, more than half (53 percent) were repeaters. Furthermore, 80 percent of all 1974 examinees had completed two or more years of medical school, with the largest concentration (58 percent) occurring in the two-year category (Table 3).

Test scores on Part I of the NBME tests ranged from 015 to 675. Of the passing group, 131 (37 percent) achieved total scores of 500 or better (380 is the minimum total passing score). In addition, 54 performed well enough in anatomy, biology, and physiology to qualify for possible second-year admissions.

Pass rates by host countries of examinee groups of 10 or more are given in Table 4. In comparison with 1973, changes in ranking were observed for all countries except Switzerland and Italy (1). These pass rates, however, should be regarded with caution, because they are based (except for Mexico) on totals which are too small for definitive judgments. Moreover, students from foreign medical schools represent rather diversified backgrounds. Some had to repeat premedical science courses since most countries no longer grant exemptions, but many more had to complement foreign instruction with considerable self-study using American textbooks.

Advanced Standing Admissions

In the five years of COTRANS history, 826 U.S. students from foreign medical schools were admitted with advanced standing by U.S. medical schools. Prior to the COTRANS program, only 20 to 30 similar admissions per year occurred. Of the five-year total, 262 (32 percent), the largest annual group to date, were admitted in the fall of 1974.

The 262 who were successful in 1974 represent a 71 percent increase over the 153 admitted in 1973. Eight medical schools accepted from 10 to 33 students each, eight reported 5 to 9 each, and the remainder accepted 1 to 4. As in previous years, 99 percent of earlier COTRANS students who were admitted were expected to graduate on schedule.

Although performance in Part I of the NBME examinations constitutes only one of the prerequisites for admission consideration, it is not surprising that examinees with total test scores approximating 500 (the mean score) or above encountered less difficulty in being admitted than those who barely passed.*

* U.S. students from foreign medical schools are taking Part I of the NBME tests for evaluation purposes only and not as candidates. Upon matriculation at a U.S. medical school, however, COTRANS examinees may apply to the National Board of Medical Examiners for conversion of Part I results to candidate status.

Conclusion

Foreign medical education continues to be a speculative venture at best. Each year, admission policies in foreign countries tend to become more and more restrictive for applicants from industrialized nations, and high dropout rates for first-year students at some foreign schools appear to persist (2). Some students are consistently unable to pass Part I of the NBME tests in the three attempts allowed, and others encounter scheduling conflicts between foreign and U.S. examinations. In considering foreign medical education as an alternative to U.S. medical education, serious thought must be given to the high potential of emotional and financial risk involved in a project that offers no guarantees of a successful outcome.

W. F. Dubé
Associate Director
AAMC Division of Student Studies
Washington, D.C.

References

1. Dubé, W. F. COTRANS and the U.S. Citizen Studying Medicine Abroad (Datagram). *J. Med. Educ.* **49**:394–397, 1974.
2. Dubé, W. F. Are Foreign Medical Schools Desirable Alternatives? *Advisor*, **10**:3–6, April 1974.

STATUS REPORT ON MEDICAL STUDENT ASSISTANCE

There is a growing crisis in financial aid to needy medical students. This Status Report was prepared by Robert Boerner, Director of the Division of Student Programs, and is included in this agenda for information. The Council of Deans will also be discussing this problem at their meeting.

STATUS REPORT ON MEDICAL STUDENT ASSISTANCE

To illustrate the severity of the crises in student assistance, in the 1974-75 academic year the total amount of financial aid needed by medical students as determined by the 109 medical schools which reported on the Liaison Committee on Medical Education Annual Questionnaire was $92.8 million. That same survey showed only $52.8 million from all sources disbursed by the schools to the 24,192 students (46.8% of the total enrollment) who evidenced financial need. Despite the fact that the additional funds from major sources not administered by the schools totaled an additional $37.9 million raising available funds to $90.5 million the situation in 1974-75 was critical.

In 1975-76 it has become worse. The Health Professions Scholarship Program which supplied $6.3 million to medical schools in fiscal year 1974 was reduced to $2.8 million in fiscal year 1975, and this year has been eliminated entirely. The $15.1 million available to medical schools through the Health Professions Loan Program in fiscal year 1975 has been reduced to approximately $10 million this year with first-year students no longer eligible for these funds. In addition, financial aid officers across the country are reporting that it is exceedingly difficult this year for medical students to receive funds from banks through the Federally Insured Guaranteed Student Loan Program which in 1974-75 supplied $28.3 million to medical students.

The other two major Federal programs, the Public Health Service/National Health Service Corps Scholarship Program and the Armed Forces Health Professions Scholarship Program are not in a strict sense financial aid programs since each requires a service commitment and neither uses financial need as a primary selection criteria. Students who actually need funds to complete their medical education, therefore, may not be selected to either program.

The funds from the Public Health Service program for a given year have thus far not been available to students until the academic year is at least half completed which further reduces their usefulness as a source of support.

In the private sector National Medical Fellowships which provides scholarships to first and second year minority medical students based on support which is solicited from various private foundations has reduced its awards from $2.3 million in 1974-75 to $1.8 million in 1975-76. In 1972-73 the Robert Wood Johnson Foundation made available $10 million in financial assistance to the medical and osteopathic schools to be used over a four year period either as loans or scholarships for minority, female and rural students. These funds which have been apportioned by the schools at approximately $2.5 million per year since 1972-73 will terminate at the close of the current academic year. The majority of this money has been made available as scholarships and thus will not be repayed in the future to be again used as financial assistance to students. The American Medical Association Education and Research Foundation which is the other major source of assistance to medical students from the private sector made available $4.6 million in 1974-75. Their forecast for 1975-76 is that approxiamtely $5.0 million will be loaned.

Thus it appears that the financial need of students in 1974-75 exceeded existing major funds from both the private and public areas by approximately $2.3 million. Although complete data is not yet available, we know that there have been the above reported decreases in the amount of financial assistance available in 1975-76 approximating $8.0 million. At the same time due to the uncertainty of Federal funding and many other factors medical school tuition since 1974-75 has and will continue to rise significantly as will living expenses due to inflation.

Therefore the financial need of medical students has increased over the past year while the amounts available in the form of financial assistance from all sources had decreased. The present disparity between necessary and existing major sources of financial aid to medical students certainly exceeds $10.3 million and may be as much as $15 to $20 million.

The most recent Association attempts to deal with these problems began on November 5 when members of the Group on Student Affairs (GSA) Committee on Financial Problems of Medical Students and AAMC staff met with several HEW policy analysts to discuss the current problems of financial assistance to students in the face of rising tuition, the drop in available health professions loans, the phaseout of the health professions scholarships, the hesitation on the part of banks to make guaranteed or private loans, the impending termination of Robert Wood Johnson funds for women, minority and rural students, and the decrease in foundation support for National Medical Fellowships and for student assistance in general. The committee members evidenced concern about the Administration proposal for a grant program for minority students for two years of premedical education and for the first year of medical school and suggested that grants for minorities include at least the first two years of medical school. The committee members proposed an extension of the Health Professions Loan Program for three years at the $50 million level. With BHM clearance the AAMC made available data from the recent survey on "How Medical Students Finance Their Education" to the analysts on the HEW staff to aid their planning. Following this meeting HEW has indicated its recommendation for a phaseout of the Health Professions Loan Program adding that an income-related loan program is being considered.

On November 18, 1975 AAMC testimony presented before the Subcommittee on Health of the Senate Labor and Public Welfare Committee ranked the need for student assistance a high priority for consideration. It stressed the need for "continuation and expansion of the Health Professions Loans" at the level of $50 million annually to prevent economic exclusion from medical school in the face of increasing education expenses and the increased cost of living.

Another area of Association activity has addressed the ineligibility of first year students for Health Professions Loan funds which resulted on June 30, 1975 from the expiration of the fiscal 1975 resolution continuing the provisions of this loan program as part of the Health Manpower Education Act of 1971. To alleviate this situation an amendment supported by the Association which would renew the eligibility of first year students for these loan funds was added to the Senate version of the current Heart-Lung Bill. The Seante has passed this bill and the amendment, and the bill is presently in conference. The House passed an earlier version which did not include the amendment. Indications are that the House members of the Conference Committee will support the amendment, but there is no clear timetable for emergence of the bill from the committee or signature or veto by the President.

Another recent development has been an inquiry from the Kellogg Foundation about the status of financial assistance to medical students. In response to that inquiry the Association provided data which may generate further interest in the problem and possibly some type of financial assistance for medical students on the part of the Foundation.

American Society of Hematology

December 23, 1975

Doctor August G. Swanson
Director of Academic Affairs
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Doctor Swanson:

The Executive Committee of the American Society of Hematology at its meeting in Dallas in December 1975 decided to withdraw the application of our Society for membership in the Council of Academic Societies of the Association of American Medical Colleges. We do appreciate your kindness and the willingness of the Council to accept our Society in membership.

Sincerely yours,

C. Lockard Conley

C. Lockard Conley, M.D.
President

CLC:b
CC Dr. Thomas B. Bradley