

NOV 11 1975



## ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

November 10, 1975

M E M O R A N D U M

TO: Mary H. Littlemeyer  
 FROM: Mignon Sample *MS*  
 SUBJECT: 1975 CAS Annual Meeting

According to the attendance sheets for the November 3, 1975 CAS Meeting, 65 persons attended representing 43 of 56 societies.

The following societies were not represented at the meeting:

American Academy of Neurology  
 American Association for the Study of Liver Diseases  
 American Neurological Association  
 American Society for Clinical Investigation, Inc.  
 American Society of Therapeutic Radiologists  
 American Urological Association  
 Association of American Physicians  
 Biophysical Society  
 Central Society for Clinical Research  
 Society of Critical Care Medicine  
 Society of Surgical Chairmen  
 Society of University Otolaryngologists  
 Southern Society for Clinical Investigation

The following individuals were elected to the CAS Administrative Board: A.J. Bollet, M.D. (Chairman-Elect), Philip R. Dodge, M.D. (one-year term), Daniel Freedman, M.D. (three-year term), Carmine D. Clemente, (three-year term), Donald W. King, Jr., M.D. (one-year term), and Leslie T. Webster (three-year term).

The 1976 Nominating Committee was elected as follows: Basic Sciences - James B. Preston, Frank E. Young, and Ronald W. Estabrook; Clinical Sciences - John E. Steinhaus, Floyd W. Denny and David R. Hawkins.

cc: Drs. Thomas Morgan and August Swanson

COUNCIL OF ACADEMIC SOCIETIES  
1975 ROLL CALL

ALLERGY

American Academy of Allergy

Paul P. Vamarel

ANATOMY

American Association of Anatomists

John E. Pauly

Carmine D. Clemente

Association of Anatomy Chairmen

Sam L. Clark

Roy C. Swan

W. Curtis Worthington

ANESTHESIOLOGY

Association of University Anesthetists

G.W. A. Eggers

Douglas W. Eastwood

Society of Academic Anesthesia Chairmen, Inc.

John E. Steinhaus

BIOLOGICAL CHEMISTS

American Society of Biological Chemists

Ronald W. Estabrook

William J. Rutter

CLINICAL LABORATORY

Academy of Clinical Laboratory Physicians & Scientists

Ellis Benson

Paul E. Strandjord

CLINICAL RESEARCH

American Association for the Study of Liver Diseases

American Federation for Clinical Research

Gerald F. DiBona

David R. Challoner

American Society for Clinical Investigation, Inc.

Central Society for Clinical Research

Southern Society for Clinical Investigation

CRITICAL CARE MEDICINE  
Society of Critical Care Medicine

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DERMATOLOGY  
Association Of Professors of Dermatology

Philip C. Anderson

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J. Graham Smith

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ENDOCRINOLOGY  
Endocrine Society

Robert M. Blizzard

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FAMILY MEDICINE  
Society of Teachers of Family Medicine

F. Marion Bishop

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Robert E. Rakel

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GASTROENTEROLOGY  
American Gastroenterological Association

Thomas R. Hendrix

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MEDICINE  
American College of Physicians

Richard Uitter

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Robert G. Peterodaf

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Association of American Physicians

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Association of Professors of Medicine

*Eugene Braunwald*

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MICROBIOLOGY

Association of Medical School Microbiology Chairmen

*Frank E. Young*

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NEUROLOGY

American Academy of Neurology

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American Neurological Association

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Association of University Professors of Neurology

*Phillip Swanson*

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NEUROSURGERY

American Association of Neurological Surgeons

W. Eugene Stern

OBSTETRICS AND GYNECOLOGY

Association of Professors of Gynecology and Obstetrics

Benny Waxman

OPHTHALMOLOGY AND OTOLARYNGOLOGY

American Academy of Ophthalmology and Otolaryngology

Bruce E. Spivey

Gary K. Thomas

Association of University Professors of Ophthalmology

F.T. Fraumfelder

Society of University Otolaryngologists

ORTHOPAEDICS

American Academy of Orthopaedic Surgeons

Frank C. Wilson

Charles U. Heck

Association of Orthopaedic Chairmen

William J. Kane

PATHOLOGY

American Association of Pathologists and Bacteriologists

Rolla B. Hill

Association of Pathology Chairmen, Inc.

Fairfield Goodale

Ellis Benson

PEDIATRICS

American Pediatric Society

Floyd W. Denny

William G. Thurman

Association of Medical School Pediatric Department Chairmen, Inc.

Marvin Cornblath

T. K. Oliver

Society for Pediatric Research

Gordon Avery

PHARMACOLOGY

Association for Medical School Pharmacology

Leolie T. Webster

Paul Munson

PHYSIATRY

Association of Academic Physiatrists

Alisa E. Hastings

PHYSIOLOGY

American Physiological Society

Robert M. Berne

Association of Chairmen of Departments of Physiology

James B. Preston

Biophysical Society

PLASTIC SURGERY

American Association of Plastic Surgeons

Robert M. McCormack

Plastic Surgery Research Council

Thomas J. Krizek

John E. Hoopes

PREVENTIVE MEDICINE

Association of Teachers of Preventive Medicine

Douglas Scutchfield

PSYCHIATRY

American Association of Chairmen of Departments of Psychiatry

David R. Hawkins

Daniel Freedman

Association for Academic Psychiatry

Larry B. Silver

Louis F. Rittelmeyer

RADIOLOGY

American Society of Therapeutic Radiologists

Association of University Radiologists

Gerald T. Scanlon

John R. Amberg

Society of Chairmen of Academic Radiology Departments

Harold G. Jacobson

James Youker

SURGERY

American Association for Thoracic Surgery

Clarence S. Weldon

American Surgical Association

Jack W. Cole

Association for Academic Surgery

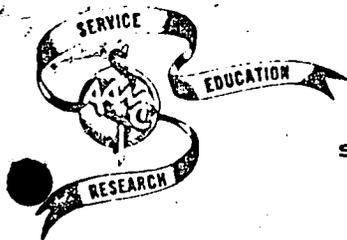
Hiram C. Polk

Society of Surgical Chairmen

Society of University Surgeons

Hiram C. Polk





ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

October 22, 1975

MEMORANDUM

TO: CAS Administrative Board

FROM: August G. Swanson, M.D. 

SUBJECT: CAS Meeting - Monday, November 3

Attached is a copy of a tentative time schedule for the CAS Meeting on Monday. In order to ensure that the Meeting runs as smoothly as possible this year, we would appreciate any assistance you can provide in keeping the meeting on this schedule.

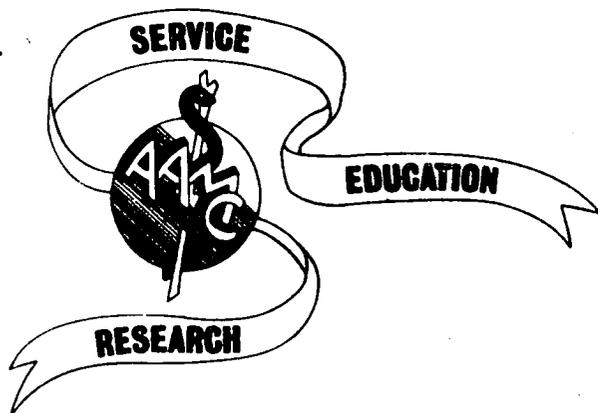
Attachment

AGS/ms

COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING AGENDA  
Monday, November 3, 1975  
Ballroom West

TIME SCHEDULE

- 9:00 a.m. Call To Order
- I. Consideration of Minutes
- II. Chairman's Report  
President's Report  
Director's Report
- 10:00 a.m. III. New Membership Applications
- IV. Election of 1975-76 Administrative Board
- 10:45 a.m. V. Health Manpower
- 11:30 a.m. Adjourn for Lunch
- 1:30 p.m. VI. Announcement of Election Results
- VII. Election of 1976 Nominating Committee
- VIII. Discussion Items
- 2:00 p.m. President's Biomedical Research Panel
- 2:15 p.m. Biomedical Research Training
- 2:30 p.m. Coordinating Council on Medical Education
- 3:00 p.m. Continuing Medical Education
- 3:30 p.m. Confidentiality of Research Grant Protocols
- 4:00 p.m. AAMC Response to GAP Committee Report
- 4:15 p.m. Borden and Flexner Awards Nominations
- 4:30 p.m. CAS Brief
- 4:40 p.m. Input into Retreat Agenda
- 4:45 p.m. IX. Information Items
- Commission for the Protection of Human Subjects
- AAMC Data Systems
- AAMC/NLM Educational Materials Project
- Medical College Admissions Assessment Program
- Study of Three-Year Curricula
- National Citizens Advisory Committee
- CAS Spring Meeting
- CAS Membership Changes
- Annual Meeting Program Outlines
- X. New Business
- 5:00 p.m. Adjourn



**AGENDA**  
**FOR**  
**COUNCIL OF ACADEMIC SOCIETIES**

ANNUAL MEETING

Monday, November 3, 1975

9:00 a.m. - 5:00 p.m.

Washington Hilton Hotel  
Ballroom West  
Washington, D.C.

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

One Dupont Circle

Washington, D. C.

AAMC ANNUAL MEETING  
November 2-6, 1975

Washington Hilton Hotel  
Washington, D.C.

1976 MEETING DATES

CAS Administrative Board Meetings

January 13-14, 1976

March 24-25, 1976

June 23-24, 1976

September 15-16, 1976

Washington, D.C.

CAS Spring Meeting

March 16, 1976

Philadelphia, Pennsylvania

AAMC Annual Meeting

November 12-16, 1976

San Francisco, California

COUNCIL OF ACADEMIC SOCIETIES  
ANNUAL MEETING AGENDA

Monday, November 3, 1975  
9:00 am - 5:00 pm  
Ballroom West - Washington Hilton Hotel  
Washington, D.C.

Page

9:00 a.m. I. Call to Order

II. Consideration of Minutes of CAS Business Meeting,  
November 12, 1974 . . . . . 1

III. Chairman's Report  
President's Report  
Director's Report, Department of Academic Affairs

IV. ACTION ITEMS:

1. New Membership Applications:

- *American Society of Hematology* . . . . . 8
- *American Society of Plastic and  
Reconstructive Surgeons* . . . . . 10
- *Association of Medical School  
Departments of Biochemistry* . . . . . 12
- *Society for Gynecological Investigation* . . . . . 14
- *American College of Obstetricians  
and Gynecologists\** . . . . . 16  
(\*Applying for reinstatement)

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11:30 a.m. Adjourn for Lunch

1:30 p.m. VI. Announcement of Election Results

VII. Election of 1976 Nominating Committee

Continued . . .

CAS ANNUAL MEETING AGENDA

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X. NEW BUSINESS

5:00 p.m. Adjourn

MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
BUSINESS MEETING

November 12, 1974

Conrad Hilton Hotel  
Washington, D.C.

I. Call to Order

The meeting was called to order at 2 p.m. Dr. Ronald W. Estabrook, Chairman, presided. Seventy individuals, representing 45 of the 57 member societies, were present. Societies not represented were:

American Association for the Study of Liver Diseases  
American College of Obstetrics/Gynecology  
American College of Psychiatrists  
American Pediatric Society  
American Society for Clinical Investigation, Inc.  
American Society of Biological Chemists  
American Society of Therapeutic Radiologists  
Association for Medical School Pharmacology  
Association of Professors of Medicine  
Association of University Radiologists  
Biophysical Society  
Society of Surgical Chairmen

II. Approval of Minutes

The minutes of the meeting held March 7, 1974 were approved as circulated.

III. Chairman's Report

A copy of the report given by the Chairman was distributed to the membership.

IV. President's Report - John A.D. Cooper

Since options for Association policy on federal funding of medical schools was on the agenda, this was not taken up as a specific item in the President's Report. Dr. Cooper commented on the Washington scene as characterized by confusion. The change from the Nixon Administration to the Ford Administration has not to date been reflected in the policies with regard to the health area. An openness, however, now exists, and it is hoped that more opportunity will be given for discussion with policy-makers of the federal government. The adversarial position between the Executive and the Congressional branches which started in the Johnson Administration continues in the Ford Administration. Mr. Ford has advocated a National Health Insurance, a stance felt to enhance his position with the nation during the remainder of his term.

Dr. Cooper spoke of the appointment of Paul O'Neill, successor to Fred Malek, as Deputy Director of the Office of Management and Budget. Mr. O'Neill is very knowledgeable about the health area, is a sound thinker, and is experienced by his previous role in OMB. He will be interested much more in program analysis and justification than his predecessor -- a fact interpreted to mean that to get its budgets through OMB, the DHEW will need to provide a much greater substantiation of programs.

Another event that will affect medical education is the enactment of the Congressional Budget and Impoundment Control Act (PL 93-344) which establishes new House and Senate Committees on the Budget and generally revises the Congressional budget review process. The law establishes a Congressional Budget Office (CBO) staffed by budget experts (without regard to political affiliation) to provide a continuing "scorekeeping" analysis of the federal budget, appropriations and authorizations bills, revenues and receipts, and changing revenue conditions. The CBO is to attempt to analyze all public bills (estimating five-year costs, compatibility with budget targets, etc.) and to provide general budget information for Congressional Committees.

In the past, each of the Appropriations Subcommittees has acted more or less independently with no real overview of the entire appropriations process by the House before the total of the appropriations comes out. The budget reform will in essence result in an examination of the health budget under closer scrutiny by the budget control committee comprised of Congressmen and Senators who are not advocates for health. They will have to approve the subcommittee recommendations before they can be enacted finally and appropriated.

V. Report of the Director, Department of Academic Affairs - August G. Swanson

Dr. Hilliard Jason, formerly of Michigan State University College of Human Medicine and most recently serving a two-year appointment as Special Education Consultant to the National Library of Medicine, joined AAMC in September heading a newly created program, the Division of Faculty Development. Dr. Jason is well-known in medical education and is especially well qualified to assume this responsibility.

Dr. Tom Morgan, now at the University of Washington-Seattle, joins the AAMC as Director of the Division of Biomedical Research effective January, 1975, succeeding Dr. Mike Ball. Dr. Morgan has extensive research experience and currently serves on the Council of the Heart and Lung Institute.

As had Drs. Estabrook and Cooper before him, Dr. Swanson expressed regret in losing Dr. Ball whose resignation becomes effective December 31, 1974.

Dr. Swanson reported on three major projects related to direct services to the medical schools and to the CAS:

1. Under the direction of Dr. William Cooper, the Educational Materials Project has made excellent progress toward the development of a clearinghouse system for nonprint multimedia learning materials. Review panels nominated by various officers of the CAS member societies have now evaluated over 2,800 items of audiovisual learning materials. It is anticipated that by next year a limited number of titles with full abstract descriptions will be available through a National Library of Medicine computer system similar to MEDLINE called AVLINE.

2. The Medical College Admission Assessment Program (MCAAP), the AAMC's program to revise the Medical College Admission Test (MCAT), is well under way. Through contract with a national testing agency, AAMC is developing an entirely new set of cognitive exams. This will be targeted on the development of exams to assess reading comprehension, quantitative ability, and achievement of knowledge in biology, chemistry, and physics. Simultaneously the MCAAP is beginning to work on developing systems and methods for exploring noncognitive variables in the assessment of students for selection to medical school.

3. Through support from the Bureau of Health Resources Development within the next year the Division of Educational Measurement and Research will be doing an in-depth study of the 3-year curriculum movement in this country. This study will concentrate on the characteristics and the outcomes of the 3-year curriculum efforts in about 17 U.S. medical schools and will match those against a control group of schools with 4-year curricula.

## VI. Action Items

### A. New Application

ACTION: The application for membership of the Society for Critical Care Medicine was unanimously approved.

### B. Nominations for the Borden Award for Outstanding Biomedical Research

Regulations regarding nominations for the Borden Award appeared in the CAS Agenda on page 12. The CAS Administrative Board recommended that the process of nomination be expanded to provide for each society's submitting one nomination for the Borden Award. In the past solicitations for nominations were sent only to members of the Assembly.

ACTION: The recommendation by the Administrative Board that each Society submit at least one nomination for the Borden Award for Outstanding Biomedical Research was unanimously approved.

C. Report of AAMC Task Force on GAP Committee Report of NBME

CAS held a detailed discussion of the AAMC Task Force Report on the Goals and Priorities Committee recommendations to the National Board of Medical Examiners. The CAS agreed with the concept of a universal qualifying exam, to be required of all students prior to entering graduate medical education, but strongly recommended that the present Parts I, II, and III of the National Boards not be abandoned until such time as a new qualifying exam has been thoroughly tried and its validity determined. The Council also strongly recommended that the Liaison Committee on Medical Education require that in the process of accrediting medical schools, data on student achievement acquired from external evaluations be provided to the accrediting team. This recommendation grew out of a serious concern by the CAS that the basic and clinical sciences content of medical education not be further eroded. The Council also recommended that the results of a qualifying exam be transmitted to the medical schools and to the graduate programs to which students are applying.

D. Dr. Neal L. Gault, Jr., M.D., Chairman of the AAMC Task Force, Dr. Edmund Pellegrino, Chairman of the NBME Advisory Committee on Undergraduate Medical Evaluation, Dr. Robert A. Chase, President of the NBME were present to participate in these deliberations. After an extensive discussion, the CAS took the following action:

ACTION: The Council accepted the "Gault" Report as submitted in the Agenda on pages 23-24 with the following modifications.

1. Delete Paragraph No. 1 and substitute the following:

The Task Force believes that the 3-part system should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school graduates in both the basic and clinical science aspects of medical education.

2. Delete Paragraph Nos. 2 and 3 and substitute the following:

Be it resolved that the AAMC recommend that the Coordinating Council on Medical Education and the Liaison Committee on Medical Education require as a part of the accreditation process that medical schools provide evidence of utilizing external evaluation data in the assessment of the educational achievement of students as they progress through a school's curriculum with continuing emphasis on the basic sciences.

3. Accept the first paragraph of Paragraph No. 4 with only one recommendation (g): that graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.

The other sub-paragraphs listed as recommendations in this item (a-f) should be transmitted to the National Board as information items. The first three of these, a-c, should be transmitted without change. Item (d) is modified to read:

The results of the exam should be reported to the students and through the students to the graduate programs to which they are applying and to the licensing boards that require certification for graduate students.

Item (e) is modified to read:

The exam results may be reported to medical schools if they request them.

Item (f) is unchanged.

4. Paragraph Nos. 5, 6, and 7 are accepted without change.
5. A final paragraph should be added to direct the National Board of Medical Examiners to administer the examination early enough in the student's terminal year that the results can be transmitted to the program directors without interference in the matching plan.

E. Options for Association Policy on Federal Funding of Medical Schools

Dr. D.C. Tosteson, Chairman of the AAMC, was present to review the options for AAMC policy on federal funding of medical schools and to respond to questions of the Council of Academic Societies. The need for the faculties to assure that the programs of medical education not be dictated by federal legislation was reiterated by Dr. Estabrook and others. The purpose of the discussion was to permit the Council of Academic Societies the greatest possible contribution to the variety of options that would be more fully developed at the subsequent meeting of the Assembly. Although an action was not required, the Council of Academic Societies wished to go on record as having taken the following action.

ACTION: The Council voted unanimously to support the following action taken by the CAS Administrative Board on September 19:

The CAS Administrative Board voted unanimously to recommend that the AAMC be advised of the faculty's concern about the portions of the proposed HPEA bill that constrain and impinge upon the integrity of undergraduate and graduate medical education even to recommend the defeat of the total bill. The CAS Administrative Board further recommends that every Dean and every Board of Trustees seek every opportunity to obtain funding through alternative means such as tuition increases, increased support from state legislatures, or a decrease in faculty size where necessary to preserve the role of the medical schools in developing and implementing educational programs.

F. Election of Nominating Committee

ACTION: The Council of Academic Societies elected the following to constitute the 1975 CAS Nominating Committee.

From the Clinical Sciences:

G.W.N. Eggers, Jr., M.D., University of Missouri  
William L. Parry, M.D., University of Oklahoma  
Daniel Freedman, M.D., University of Chicago

From the Basic Sciences:

Carmine D. Clemente, Ph.D., UCLA  
James B. Preston, M.D., SUNY Upstate Medical Center

G. Resolution from the Society of Academic Anesthesia Chairmen

ACTION: The resolution from the Society of Academic Anesthesia Chairmen regarding the critical shortage of academic anesthesiologists was referred for consideration to the CAS Administrative Board.

H. U.S. Faculty Visiting at the Universidad Autonoma de Guadalajara

The questions posed by this situation were summarized in the Agenda on page 66. Dr. Eastwood suggested that it would be helpful if the AAMC's opinion of the Guadalajara operation could be made available to students. With regard to the major question of involvement of U.S. faculty at Guadalajara, the opinion was expressed by Dr. Relman that this issue was inappropriate for action of the CAS but rather should be a matter for attention of the individual U.S. medical school administrations. Dr. Relman's statement was accepted as the consensus of the CAS.

I. Election of Members to the 1974-75 CAS Administrative Board

ACTION: The Council elected by ballot the following to serve on the CAS Administrative Board effective 1974-75:

Chairman-Elect

Rolla B. Hill, Jr., M.D., SUNY Upstate Medical Center

For Administrative Board, from the Basic Sciences

Robert M. Berne, M.D., University of Virginia  
F. Marion Bishop, Ph.D., University of Alabama

For Administrative Board, from the Clinical Sciences

David R. Challoner, M.D., Indiana University  
Thomas K. Oliver, Jr., M.D., University of Pittsburgh

J. Installation of Chairman

ACTION: Dr. Jack W. Cole was installed as Chairman of the Council of Academic Societies for 1974-75.

K. Commendations

ACTION: In separate actions by acclamation the Council expressed sincere appreciation and congratulations for their leadership and service to Dr. Ronald W. Estabrook, CAS Chairman for 1973-74, and to Dr. Michael F. Ball, Director of the AAMC Division of Biomedical Research, August 1, 1972-December 31, 1974.

VII. Adjournment

ACTION: The meeting was adjourned at 5:20 p.m.

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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 SOCIETY OF HEMATOLOGY

MAILING ADDRESS: Ropes & Gray (Principle Ofc) Dr. Thomas B. Bradley (direct correspondence  
\* 225 Franklin Street Secretary to this address)  
Boston, MA 02110 V.A. Hospital  
4150 Clement St.  
San Francisco, CA 94121

PURPOSE: The purposes of this corporation shall be to engage exclusively in charitable, scientific and educational activities and endeavors including specifically but not limited to promoting and fostering, among the many scientific and clinical disciplines, the exchange and diffusion of information and ideas relating to blood and blood-forming tissues and encouraging investigations of hematologic matters. No substantial part of the activities of the corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation; nor shall this corporation participate or intervene, by publishing or distributing statements or in any other way, in any political campaign on behalf of any candidate for public office.

MEMBERSHIP CRITERIA: Any person with a doctoral degree or its equivalent, who is a permanent resident of any American country and who has manifested a continuous interest in any discipline important to hematology as evidenced by work in the field, original contributions, and attendance at meetings concerning hematology, is eligible for active membership.

NUMBER OF MEMBERS: 2106

NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: October 12, 1957

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Revised December 3, 1973 1. Constitution & Bylaws

December 1974 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

\* Business Office: Charles B. Slack, Inc.  
6900 Grove Road  
Thorofare, NJ 08086

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?

Section 501(c) (3) and Section 509(a)

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.

(Denise Carter) / L.M.D., President  
(Completed by - please sign)

January 20, 1975  
(Date)

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: The Educational Foundation of the American Society of  
Plastic and Reconstructive Surgeons, Inc.

MAILING ADDRESS: 29 East Madison Street, Suite 807  
Chicago, Illinois 60602

PURPOSE: See attached copy of the Educational Foundation Constitution,  
Article II, Purposes

MEMBERSHIP CRITERIA: See attached copy of the American Society of Plastic  
and Reconstructive Surgeons, Inc. Bylaws, Article III, Section I which includes  
membership in the Educational Foundation.

NUMBER OF MEMBERS: 1,231 Voting Members

NUMBER OF FACULTY MEMBERS: Not Applicable

DATE ORGANIZED: 1947

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Revised, 9/72 1. Constitution & Bylaws

1973 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

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

X  YES   NO

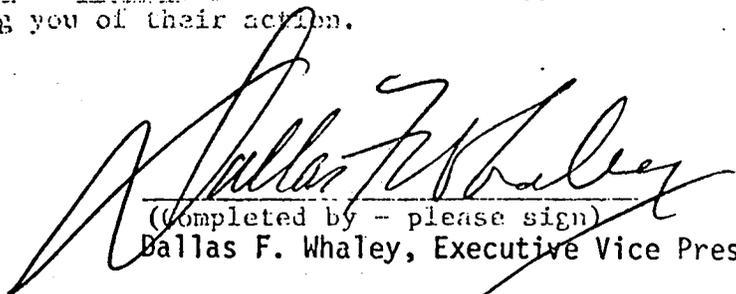
2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501 C3

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.



(Completed by - please sign)  
Dallas F. Whaley, Executive Vice President

April 18, 1975   
(Date)

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: Miss Vicki Bardloff

NAME OF SOCIETY: Association of Medical School Departments of Biochemistry

MAILING ADDRESS: Dr. Henry Z. Sable, Secretary  
Association of Medical School Departments of Biochemistry  
Department of Biochemistry  
Case Western Reserve University School of Medicine  
Cleveland, Ohio 44106

PURPOSE: To promote discussion of problems of interest and concern to  
Departments of Biochemistry located in medical school environments.

MEMBERSHIP CRITERIA:

Regular membership: Departments of Biochemistry in Medical Schools  
in the United States and Canada (and other locations  
by petition).

Associate membership: Departments of Biochemistry in Universities which  
do not have Medical Schools, but in which a special  
interest in medical or health education exists.

NUMBER OF MEMBERS: 91 Institutions.

NUMBER OF FACULTY MEMBERS: Estimated 1,500.

DATE ORGANIZED: April, 1973

SUPPORTING DOCUMENTS REQUIRED (Indicate in blank date of each document):

November 20, 1973 1. Constitution & Bylaws

February 21-23, 1975 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

YES  NO

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

Section 501 (c) (3)

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

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.

Carl S. Vestling  
(Completed by - please sign)

10 July 1975  
(Date)

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: The Society for Gynecologic Investigation

MAILING ADDRESS: c/o Thomas H. Kirschbaum, M.D., Secretary-Treasurer  
Department of Obstetrics and Gynecology  
178 Giltner Hall  
Michigan State University  
East Lansing, Michigan 48824

PURPOSE:

To stimulate, encourage, assist, and conduct fundamental gynecic research, to provide opportunities for investigators in obstetrics and gynecology to enter into free exchange of ideas to the end of increasing knowledge and techniques in these fields.

MEMBERSHIP CRITERIA: Less than 46 years at initial membership, occupation of a responsible position in an institution of higher learning for not less than two years, and demonstration of promise of a continuingly productive academic career based on recent and current investigative activity.

NUMBER OF MEMBERS: 245

NUMBER OF FACULTY MEMBERS: 245

DATE ORGANIZED: 1952

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

January 1975 1. Constitution & Bylaws

March 28, 1974 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

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?

501(c)(3)

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

- X  a. Approved by IRS (May 14, 1965).
- 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.

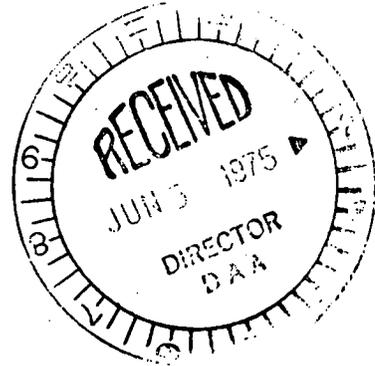
Thomas H. Kaseloban   
(Completed by - please sign)

12/12/74   
(Date)



# THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

May 30, 1975



August G. Swanson, M.D.  
Director of Academic Affairs  
Association of American Medical Colleges  
Suite 200  
One DuPont Circle, NW  
Washington, DC 20036

Dear Doctor Swanson:

At the request of the Executive Board of The American College of Obstetricians and Gynecologists, I am writing to indicate our desire to be reinstated in the Council on Academic Societies. Please consider this our application for reinstatement.

Sincerely yours,

Ervin E. Nichols, M.D., FACOG  
Director-Practice Activities

EEN/ss



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

B A L L O T

COUNCIL OF ACADEMIC SOCIETIES

1974-75

Administrative Board Positions

CHAIRMAN-ELECT

Vote for One:

BOLLET, A. J., M.D.

BOLLET, A(LFRED) J(AJ), b. N.Y.C. July 15, 26; m. 54. MEDICAL SCIENCES. B.S. N.Y. Univ, 45, M.D. 48. Res. physician, chest serv, Bellevue Hosp, N.Y.C, 50, asst. resident physician, 52-53; clin. res. assoc. Nat. Inst. Arthritis & Metab. Diseases, Nat. Insts. Health, 53-55; asst. prof. med, col. med, Wayne State Univ, 55-59; assoc. prof. prev. med. & med. sch. med, Univ. Va, 59-65, prof. internal & prev. med, 65-66; PROF. MED. & CHMN. DEPT, MED. COL. GA. 68- Asst. sch. med, Johns Hopkins Univ. 54-55; consult. physician, Baltimore City Hosp, 54-55; Markle scholar. med. sci, 56-61. Dipl. Am. Bd. Internal Med. U.S.P.H.S, 49-55. AAAS: Am. Soc. Clin. Invest; Am. Col. Physicians; Am. Fedn. Clin. Res. (pres, 63-64); Soc. Exp. Biol. & Med; Asn. Am. Physicians; Am. Clin. & Climat. Asn; Asn. Profs. Med. Clinical and laboratory studies in the rheumatic diseases. Address: Dept. of Medicine, Medical College of Georgia, Augusta, Ga. 30902.

(CAS Administrative Board, 11/73 - 11/75)

BRAUNWALD, Eugene, M.D.

BRAUNWALD, EUGENE, physician; b. Aug. 15, 1929; s. William and Clare (Wallach) B.; A.B., N.Y. U., 1949, M.D., 1952; m. Nina Starr, May 23, 1952; children—Karen, Denise, Adrienne. Tng. internal medicine Mt. Sinai, Johns Hopkins hosps, also Columbia, 1952-58; commd. USPHS, 1954, med. dir., 1963; research cardiology and physiology Nat. Heart Inst., 1955-67, chief cardiology dept., 1960-67, clin. dir. inst., 1966-68; clin. prof. medicine Georgetown U., 1966-68; prof., chmn. dept. medicine U. Cal. at San Diego Sch. Medicine, La Jolla, 1968-72; Hersey prof., chmn. dept. medicine Peter Bent Brigham Hosp., Harvard Med. Sch., Boston, 1972. Recipient John Abel award research pharmacology; Arthur Fleming award for outstanding fed. service; Outstanding Service award USPHS, 1967; Nylin award Swedish Med. Soc., 1970; Einthoven medal, 1970. Diplomate Am. Bd. Internal Medicine. Fellow A.C.P., Am. Coll. Cardiology (v.p., gov., trustee); mem. Am. Heart Assn. (v.p., dir. chmn. publs. 1965—; Research Achievement award 1972), Am. Fedn. for Clin. Research (pres. 1968-70), Soc. Clin. Investigation (pres. 1973—), Western Soc. for Clin. Research (pres. 1971-72), Am. Physiol. Soc., Am. Pharmacology Soc., Assn. Am. Physicians, Assn. Profs. Medicine (pres. 1973—). Author: Mechanism of Contraction of Heart. Editorial bd. Circulation and Jour. Pharmacology, Jour. Clin. Investigation, Am. Jour. Physiology, Annals Internal Medicine, Circulation Research, Yearbook of Cardiovascular Diseases, Yearbook of Medicine; editor: Principles of Internal Medicine, contrb. numerous sci. articles. Home: 75 Scotch Pine Rd Weston MA 02193

## B A L L O T

ADMINISTRATIVE BOARD, CLINICAL SCIENCES

Vote for Two: (One to be elected for  
one-year term\*)

DODGE, Philip R., M.D.

**DODGE, PHILIP ROGERS**, physician; b. Beverly, Mass., Mar. 16, 1923; s. Israel R. and Anna (McCarthy) D.; student U. N.H., 1941-43, Yale, 1943-44; M.D., U. Rochester, 1948; m. Martha Hoyt, Aug. 25, 1947; children—Susan, William, Judith, Intern, Strong Meml. Hosp., 1948-49; asst. resident neurology Boston City Hosp., 1949-50, resident, 1950, sr. resident, 1951-52; practice medicine, specializing in neurology, Boston, 1956-67, St. Louis, 1967—; teaching fellow neurology Harvard Med. Sch., 1950, 51-53, instr. neurology, 1955-58, asso. in neurology, 1958-61, asst. prof., 1962-67; asst. neurologist Mass. Gen. Hosp., 1956-59, dir. pediatric neurology program, 1958-67, asso. neurologist, 1959-63, asso. pediatrician, 1961-62, pediatrician, 1962-67, investigator Joseph P. Kennedy, Jr. Meml. Labs. for Study Mental Retardation, 1962-67, neurologist, 1963-67; pediatric neurologist Boston Lying-In Hosp., 1961-67; cons. in neurology Walter E. Fernald State Sch. for Retarded Children, 1963-67; med. dir. St. Louis Childrens Hosp., 1967—; asso. neurologist Barnes Hosp., 1967—; prof., head Mallinckrodt Dept. Pediatrics, Washington U. Sch. Medicine, 1967—, prof. neurology, 1967—. Vis. scientist Clin. Research Center, U. P.R., 1965-66, hon. vis. prof. physiology, 1967; cons. collaborative project on cerebral palsy Nat. Inst. Neurol. Diseases and Blindness, 1958—; bd. dirs., chmn. research adv. com. Mass. Soc. for Prevention Cruelty to Children, 1961-67; mem. sci. research adv. bd. Nat. Assn. for Retarded Children, 1963-67. Bd. dirs. Central Midwestern Regional Lab., Inc., 1967-70. Served from 1st Lt. to maj. M.C., U.S. Army, 1950-56. Diplomate Am. Bd. Psychiatry and Neurology, Mem. St. Louis Med. Soc., Am. Pediatric Soc., Am. Acad. Neurology (past com. chmn.), Am. Neurol. Assn., Assn. for Research in Nervous and Mental Disease, Soc. Pediatric Research, Soc. Biol. Psychiatry, St. Louis Soc. Neurol. Scis., Alpha Omega Alpha. Editorial bd. Jour. Developmental Medicine and Child Neurology, 1965—, Jour. Pediatrics, 1970—, Pediatric Research, 1970—; Current Problems in Pediatrics, 1969—, Neurology, 1973—. Contbr. articles prof. journals. Home: 909 Lay Rd St Louis MO 63124 Office: 500 S Kingshighway St Louis MO 63110

FREEDMAN, Daniel, M.D.

**FREEDMAN, DANIEL X.**, psychiatrist, educator; b. Lafayette, Ind., Aug. 17, 1921; s. Harry and Sophia (Feinstein) F.; B.A., Harvard, 1947, M.D., Yale, 1951; grad. Western New Eng. Inst. Psychoanalysis, 1966; m. Mary C. Neidigh, Mar. 20, 1945. Intern pediatrics Yale Hosp., 1951-52, resident psychiatry, 1952-55; from instr. to prof. psychiatry Yale, 1955-66; chmn. dept. U. Chgo., 1966—. Louis Block prof. biol. scis., 1969—; career investigator USPHS, 1957-66; dir. psychiatry and biol. sci. tng. program Yale, 1960-66; cons. Nat. Inst. Mental Health, 1960—, U.S. Army Chem. Center, Edgewood, Md., 1965-66. Chmn. panel psychiat. drug efficacy study Nat. Acad. Sci.-NRC, 1966; mem. adv. com. FDA, 1967—; rep. to div. med. scis. NRC, 1971-73, mem. com. on brain scis., 1971-73, mem. com. on problems of drug dependence, 1971—. Dir. Found. Fund for Research in Psychiatry, 1969-72, Drug Abuse Council, 1972—. Served with AUS, 1942-46. Fellow Am. Psychiat. Assn. (chmn. commn. on drug abuse 1971—), Am. Coll. Neuropsychopharmacology (pres. 1970—); mem. Ill. Psychiat. Soc. (pres. 1971-72), Social Sci. Research Council (dir. 1968-69), Chgo. Psychoanalytic Soc., Western New Eng. Psychoanalytic Inst., Am. Soc. Pharmacology and Exptl. Therapeutics, A.A.A.S., Am. Assn. Chairmen Depts. Psychiatry (pres. 1972-73), Am. Psychopath. Assn., Group Advancement Psychiatry, Psychiat. Research Soc., Am. Psychosomatic Soc. (councillor 1970-73), Soc. Biol. Psychiatry, Sigma Xi, Alpha Omega Alpha. Author: (with N.J. Giarmar) Biochemical Pharmacology of Psychotomimetic Drugs, 1965, What Is Drug Abuse?, 1970; (with F.C. Redlich) The Theory and Practice of Psychiatry, 1966; (with D. Offer) Modern Psychiatry and Clinical Research, 1972. Home: 4950 S Chicago Beach Dr Chicago IL 60615 Office: 950 E 59th St Chicago IL 60637

GLENN, James F., M.D.

**GLENN, JAMES FRANCIS**, b. Lexington, Ky, May 10, 28; m. 48; c. 4. UROLOGY. B.A. Rochester, 50; Kentucky; M.D. Duke, 53. Intern gen. surg, Peter Bent Brigham Hosp, Boston, Mass, 52-54; resident urol. surg, med. ctr, Duke, 56-59, asst. urol, sch. med, 56-58, instr, 58-59; asst. prof, Yale, 59-61; assoc. prof, Bowman Gray Sch. Med, 61-63; PROF. UROLOG. & CHIEF UROLOG. SURG, MED. CTR, DUKE UNIV, 63- Asst. surgeon, Grace-New Haven Hosp, 59-61; attend. urol, N.C. Baptist Hosp, 61-63; consult, Vet. Adm. Hosp, Durham, 63-; Watts Hosp, 64-; Lincoln Hosp, 65- Med.C.Res, 53-55, Capt. Am. Col. Surg; Am. Urol. Assn; Soc. Pediat. Urol; Int. Soc. Urol; Am. Assn. Genito-Urinary Surg; Soc. Univ. Urol. (pres). Adrenal surgery; pediatric urology; genitourinary malignancies. Address: Dept. of Urology, Duke University Medical Center, Durham, NC 27706.

POLK, Hiram C., M.D.

**POLK, HIRAM CAREY**, b. Jackson, Miss, Mar. 23, 36; m. 56; c. 2. GENERAL SURGERY. B.S. Millsaps Col, 56; M.D. Harvard, 60. Instr. SURG, Wash. Univ, 64-65; asst. prof, Univ. Miami, 65-69, assoc. prof, 69-71; PROF. & CHMN. DEPT, UNIV. LOUISVILLE, 71- Clin. trainee cancer control, U.S. Pub. Health Serv, 64-65; dir. tumor cltn, Jackson Mem. Hosp, Miami, Fla, 69-71; res. assoc. path, Lister Inst. Prev. Med, 69; mem. consult. staff, Vet. Adm. Hosp, 71-; mem. attend. staff, Children's Hosp, Jewish Hosp, Norton Mem. Infirmary, St. Anthony Hosp. & St. Joseph Infirmary, 71- Asn. Acad. Surg; Soc. Univ. Surg. (treas); Am. Col. Surg; Am. Burn Assn; Am. Assn. Cancer Educ; Am. Assn. Surg. Trauma; Soc. Surg. Allimentary Tract. Surgical infection; cancer; burns. Address: Dept. of Surgery, Health Sciences Center, University of Louisville, Louisville, KY 40201.

## B A L L O T

ADMINISTRATIVE BOARD, BASIC SCIENCES

Vote for Three (One to be elected for one-year term\*)

CLEMENTE, Carmine D., Ph.D.

CLEMENTE, CARMINE DOMENIC, educator; b. Penns Grove, N.J., Apr. 29, 1928; s. Ermanno and Caroline (Friozi) C.; A.B., U. Pa., 1948, M.S., 1950, Ph.D., 1952; postdoctoral fellow U. London, 1953-54; m. Juliette Vance, Sept. 19, 1968. Asst. instr. anatomy U. Pa., 1950-52; faculty U. Cal. at Los Angeles, 1952--; prof., chmn. dept. anatomy, 1963--; Hon. research asso. Univ. Coll., U. London, 1953-54; cons. Sepulveda VA Hosp., NIH. Mem. med. adv. panel Bank Am.-Giannini Found. Mem. Pavlovian Soc. N.Am. (Ann. award 1968, pres. 1972). Brain Research Inst., Am. Physiol. Soc., Am. Assn. Anatomists (v.p. 1970-72). Am. Acad. Neurology, Am. Acad. Cerebral Palsy, Am. Neurol. Assn., Assn. Anatomy Chairmen (pres. 1972). Biol. Stain Commn., Internat. Brain Research Orgn., Med. Research Assn. Cal., N.Y. Acad. Sci., Nat. Acad. Sci. (mem. com. neuropathology, BEAR coms.), Sigma Xi, Democrat. Author: Aggression and Defense: Neurol Mechanisms and Social Patterns, 1967; Physiological Correlates of Dreaming, 1967; Sleep and the Maturing Nervous System, 1972. Asso. editor Experimental Neurology, Anatomical Record, Conditional Reflex, Brain Research, Am. Jour. Anatomy. Contbr. articles to sci. journals. Home: 11737 Bellagio Rd Los Angeles CA 90049

(CAS Administrative Board, 11/73--11/75)

GINSBERG, Harold S., M.D.

GINSBERG, HAROLD SAMUEL, virologist; educator; b. Daytona Beach, Fla., May 27, 1917; s. Jacob and Anne (Kalb) G.; A.B., Duke, 1937; M.D., Tulane U., 1941; m. Marion Reibstein, Aug. 4, 1949; children--Benjamin Langer, Peter Robert, Ann Meredith, Jane Elizabeth. Resident Mallory Inst. Pathology, Boston, 1941-42; intern, asst. resident Boston City Hosp., 4th Med. Service, 1942-43; resident physician, asso. Rockefeller Inst., 1946-51; asso. prof. preventive medicine Western Res. U. Sch. Medicine, 1951-60; prof. microbiology, chmn. dept. U. Pa. Sch. Medicine, 1960-73; prof. microbiology, chmn. dept. Coll. Phys. and Surg. Columbia, 1973--; Mem. commn. acute respiratory diseases, Armed Forces Epidemiological Bd., 1959-73; cons. NIH, 1959-72, Army Chem. Corps, 1962-64, NASA, 1969--; Am. Cancer Soc., 1969-73; v.p. Internat. Com. on Nomenclature of Viruses, 1966--; mem. space sci. bd., chmn. panel microbiology Nat. Acad. Sci., 1973--; Served to maj., M.C., AUS, 1943-46, Decorated Legion of Merit, Mem. Assn. Am. Physicians, Am. Acad. Microbiologists (chmn. bd. govs. 1971-72), Am. Society Clin. Investigation (councillor 1958-60), Am. Assn. Immunologists, Am. Soc. Microbiology (chmn. virology div. 1961-62), Soc. Exptl. Biology and Medicine, Harvey Soc., Central Soc. Clin. Research, Am. Soc. Biol. Chemists, Alpha Omega Alpha. Contbr. textbooks. Co-author: Microbiology, 1967. Editorial bds. Jour. Immunology, Jour. Exptl. Medicine, Jour. Virology and Bacteriological Reviews, Jour. Infectious Diseases, Editor Jour. Bacteriology, Intervirology. Home: 450 Riverside Dr New York City NY 10027

KING, Donald West, Jr., M.D.

KING, DONALD W(EST), (JR), b. Cochran, Pa, June 30, 27; m. 52; c. 3. PATHOLOGY. M.D. Syracuse, 49. Res. & instr. path. col. physicians & surgeons, Columbia, 49-52; U.S. Pub. Health Serv. fel, Chicago, 54-55; Carlsberg Lab, 55-56; asst. prof. PATH, Yale, 56-61; prof. & chmn. dept. Univ. Colo, Denver, 61-67; DELAFIELD PROF. & CHMN. DEPT. COL. PHYSICIANS & SURGEONS, COLUMBIA UNIV, 67- Mem. path. training comt, comt. path, Nat. Acad. Sci-Nat. Res. Coun. Med.C, 52-54, 1st Lt. Am. Soc. Exp. Path; Am. Med. Assn; Am. Asn. Path. & Bact. Interrelations between lipid, protein, nucleic acid and protein metabolism in suspension tissue culture cells in normal and abnormal environment. Address: Dept. of Pathology, College of Physicians & Surgeons, Columbia University, 630 W. 168th St, New York, NY 10032.

Continued ...

## B A L L O T

Basic Sciences (Continued)

MAREN, Thomas H., M.D.

MAREN, THOMAS H(ARTLEY), b. N.Y.C. May 26, 18; m. 41; c. 3. PHARMACOLOGY. A.B. Princeton, 38; M.D. Hopkins, 51. Res. chemist, Wallace Labs, Carter Prods, Inc, N.J, 38-40, group leader, 41-44; chemist. sch. hygiene & pub. health, Hopkins, 44-46, instr. pharmacol, med. sch, 46-51; pharmacologist, chemotherapy dept, res. div, Am. Cyanamid Co, 51-54, group leader, 54-55; PROF. PHARMACOL. & THERAPEUT. & CHMN. DEPT, COL. MED, UNIV. FLA, 55- Investr, Mt. Desert Island Biol. Lab, 53- Am. Soc. Pharmacol. & Exp. Therapeut. Renal and electrolyte pharmacology and physiology; carbonic anhydrase and its inhibitors; chemotherapy of infectious diseases; comparative pharmacology. Address: University of Florida College of Medicine, Gainesville, FL 32601.

RUTTER, William J., M.D.

RUTTER, WILLIAM J, b. Malad City, Idaho, Aug. 28, 28; m. 71; c. 2. BIO-CHEMISTRY. B.S. Harvard, 49; univ. fel, Utah, 49-50, M.S. 50; Ph.D.(biochem), Illinois, 52. Asst, Illinois, 50-52; U.S. Pub. Health Serv. fel, inst. enzyme res, Wisconsin, 52-54; biochem, Med. Nobel Inst, Sweden, 54-55; asst. prof, Illinois, Urbana, 55-60, summer fel, 57, assoc. prof, 60-63, prof, 63-65; Washington (Seattle), 65-69; HERTZSTEIN PROF. BIOCHEM. & CHMN. DEPT. BIOCHEM. & BIOPHYS, UNIV. CALIF, SAN FRANCISCO, 69- Consult, Abbott Labs, Ill, 58-; mem. phys. chem. study sect, Nat. Insts. Health, 67-71; basic sci. adv. comt, Nat. Cystic Fibrosis Found, 69-; exec. comt, div. biol. & agr, Nat. Res. Coun, 69-72; develop. biol. panel, Nat. Sci. Found, 71-; biomed. adv. comt, Los Alamos Sci. Lab, 72-75. Faculty res. award, Lalor Found, 56. AAAS; Am. Chem. Soc. (award enzyme chem, 67); Am. Soc. Biol. Chem. (treas, 70-73); Am. Soc. Cell Biol. Control of genetic transcription; regulation of gene expression; cell proliferation and morphogenesis; variations of structure and function of macromolecules in ontogeny and phylogeny; regulation of enzyme activity. Address: Dept. of Biochemistry & Biophysics, University of California, San Francisco, San Francisco, CA 94122.

WEBSTER, Leslie T., Jr., M.D.

WEBSTER, LESLIE TILLOTSON, JR., medical educator; b. N.Y.C., Mar. 31, 1926; s. Leslie Tillotson and Emily (de Forest) W. B.A., Amherst Coll., 1964; student Union Coll., 1944; M.D., Harvard, 1948; m. Alice Katharine Holland, June 24, 1955; children - Katharine White, Susan Holland, Leslie Tillotson III, Romi Anne. Intern Cleve. City Hosp., 1948-49, jr. asst. resident, 1949-50; asst. resident medicine Bellevue Hosp., N.Y.C., 1952-53; research fellow medicine Harvard and Boston City Hosp. Thorndike Meml. Lab., 1953-55; demonstrator Case Western Res. U. Sch. Medicine, 1955-56, sr. instr. biochemistry, 1959-60, asst. prof. medicine, 1960-72, asst. prof. biochemistry, 1960-65, asst. prof. pharmacology, 1965-67, asso. prof., 1967-70; prof., chmn. pharmacology dept. Northwestern U. Med. Sch., 1970 - cons. (ad hoc) Nat. Inst. Gen. Med. Scis., Nat. Inst. Arthritis and Metabolic Diseases, NIH. Served to it. USNR, 1950-52. Russell M. Wilder fellow Nat. Vitamin Found., 1956-59. Sr. USPHS Research fellow, 1959-61. Research Career Devel. awardee, 1961-69. Diplomate Am. Bd. Internal Medicine Mem. Am. Assn. Study Liver Diseases, A.C.P., Central Soc. Clin. Research, Am. Soc. Clin. Investigation, Am. Soc. Biol. Chemists, Assn. Med. Sch. Pharmacology, Am. Soc. Pharmacology and Exptl. Therapeutics. Contbr. numerous articles to med., sci. journs. Home. Cumnor Rd Kenilworth IL 60043 Office: 303 E Chicago Av Chicago IL 60611

(CAS Administrative Board, 11/73--11/75)

\*These one-year terms are replacements for Drs. David Challoner and Kay Clawson who resigned from the Board after assuming positions as Deans

## HEALTH MANPOWER

During the last twelve months since the last Annual Meeting of the Council of Academic Societies, there has been ongoing debate regarding federal support for medical education. Shortly after the 1974 Annual Meeting, an AAMC task force was appointed under the Chairmanship of Dan Tosteson and charged to review the Association's position on health manpower legislation and to develop specifications for an Association legislative proposal. Subsequently, a bill was drafted and introduced into both the House and Senate. The Association bill recommended that one-half of federal capitation be provided without any specific requirements in recognition of the fact that basic support of medical education is in part a federal responsibility. In order to qualify for the other half of capitation, schools would be required to initiate programs relative to public concerns regarding health manpower in several areas. These provisions for qualification provided sufficient flexibility that all schools could respond to public concerns in a manner best suited to their geographic, social and cultural opportunities. The bill also provided for the regulation of residency positions by the Coordinating Council on Medical Education under the authority of the Secretary of HEW.

A House bill passed in July, H.R. 5546, restricted the options for capitation to a choice of two - increasing first or third year enrollments by five percent or ten students, or developing a plan for remote site training of undergraduate medical students. A provision in the House bill providing the Coordinating Council on Medical Education an opportunity to assume responsibility for the regulation of the number of residency positions was defeated by floor amendment.

The Administration bill requires that schools, in order to qualify for capitation, set aside twenty to twenty-five percent of first year class spaces for students willing to accept National Health Service scholarships, if offered. The bill also requires that schools establish an identifiable administrative teaching unit in primary care and increase residencies in primary care in affiliated teaching hospitals to thirty-five percent in FY 1977, forty percent in FY 1978 and fifty percent in FY 1979. Schools not opting to fulfill these conditions would receive capitation on a declining scale with complete phase-out of capitation support over a four year period. There is no provision for regulation of the distribution of residency positions in the Administration bill.

The Senate Health Subcommittee is presently drafting legislation. Hopefully, the particulars of the Senate bill will be available for discussion at the CAS Annual Meeting.

## PRESIDENT'S BIOMEDICAL RESEARCH PANEL

The President's Biomedical Research Panel was created by Congress in mid-1974 and appointed February 1, 1975. At their spring meetings the Council of Academic Societies and the Council of Deans formulated opinions and presented testimony to members of the Panel. They emphasized their concern for the instability of research funding, the need for support of research training programs and basic biomedical and behavioral research, and the need for increased participation of the research community in the planning of future biomedical and behavioral research initiatives. The President's Panel set up a number of study groups of scientists whose responsibility is to examine the state of the art of 12 clusters of research endeavor and to advise the Panel what steps should be taken to conduct research more effectively in each area.

The Association took a leadership role with the staff of the President's Panel to assess the stability of research funding and the trends occurring in the pattern of federal involvement in the research effort. As a result, a study of the impact of federal research funding on the academic medical center has now been undertaken by a consortium of the AAMC, the American Council on Education and the Rand Corporation under contract with the Panel. Efforts to date have been the construction of a data base which will depict the dimensions and trends in funding of academic medical centers in the past decade. Construction of the computerized data base for addressing questions about the impact of research funding on academic medical centers is now completed.

This study of the impact of federal research funding will examine the federal role on not only research and research training support but also on faculty and student body size, construction, teaching, local management practices, and medical school curriculum change. Another related project in this study will be an exposition of present indirect cost policies and procedures at academic medical centers and universities. From the AAMC-ACE-Rand report the Panel will prepare its own report to the Congress.

## BIOMEDICAL RESEARCH TRAINING

Continuing uncertainties over the future of biomedical research training led the Administrative Board of the Council of Academic Societies to reassess its position in this area. The Administrative Board reaffirmed the 1974 position of the Committee on National Medical Policy of the American Society for Clinical Investigation that:

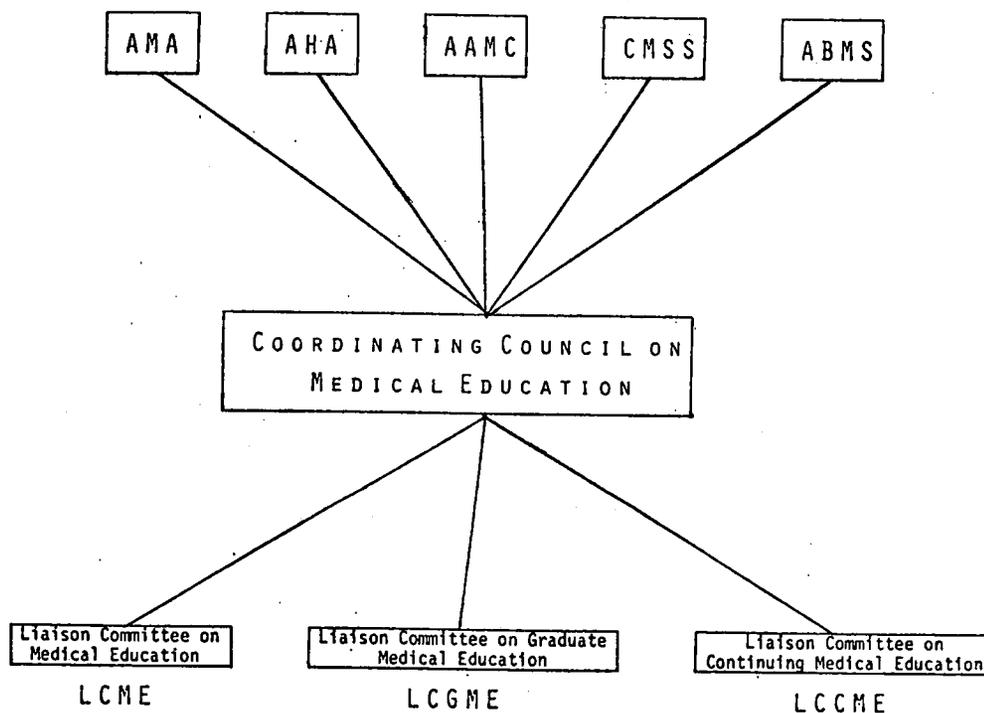
- the institutional training grant should be the key element in the biomedical research training programs of the NIH and NIMH.
- the support of training through individual fellowships lacks many of the advantages of the institutional training grant, although in the presence of a vigorous national training grant program, individual fellowships can serve as useful supplements to fulfill special needs.
- the research grant and contract are poor substitutes for stipend support through training grants.
- self-support by the trainee does not appear to be an acceptable method of financing biomedical training.
- the objective of the NIH and NIMH supported biomedical research training programs should be restricted to the development of future scientists and teachers.
- perceptive analyses of flow of personnel on the one hand, and of shortages in specific disciplines on the other, should lead to periodic decisions to launch new programs in the fields that need strengthening, and the curtailment of programs in others.

The Administrative Board believes that new federal mechanisms are needed to support biomedical research training which will permit increased flexibility in the scientific careers of the researchers. Future basic science researchers probably need broader training. Research manpower must be trained by federal programs since there is no viable alternative to federal support. It has been pointed out that just as it is inappropriate for private, state or local agencies to train military manpower for the armed forces - a national need - so it is inappropriate for private, state or local agencies to be required to train biomedical research manpower for a similar national need in health.

The perceptive analyses of personnel need which are being conducted by the Commission on Human Resources should be vigorously supported so that responsive, flexible programs for the support of research manpower training can be initiated to meet general and special research manpower needs.

COORDINATING COUNCIL ON MEDICAL EDUCATION  
AND ITS SUBCOMMITTEES

The Coordinating Council on Medical Education was established by its five parent organizations in 1972. These are the Association of American Medical Colleges, the American Medical Association, the American Hospital Association, the American Board of Medical Specialties and the Council of Medical Specialty Societies. The purpose of the Council is to provide a forum for discussion of policy questions relevant to all phases of the continuum of medical education and to establish policies to be reviewed and ratified by the parent organizations. The CCME is particularly the body which reviews, approves and forwards to parent organizations, policies relating to the accreditation of medical education. Three liaison committees have been established under the umbrella of the CCME. These are the Liaison Committee on Medical Education (LCME), which has been responsible for the accreditation of institutions offering medical education leading to the M.D. degree in the U.S. and Canada since 1942; the Liaison Committee on Graduate Medical Education (LCGME), which is responsible for the accreditation of programs in graduate medical education; and the Liaison Committee on Continuing Medical Education (LCCME), which will be responsible for the accreditation of continuing medical education. Diagrammatically, the Coordinating Council on Medical Education and its liaison committees are represented below. Members of the Council and Liaison Committees are shown on pages four and five of this report.



- AMA - American Medical Association
- AHA - American Hospital Association
- AAMC - Association of American Medical Colleges
- CMSS - Council of Medical Specialty Societies
- ABMS - American Board of Medical Specialties

The Coordinating Council and the Liaison Committees have considered several policy issues during the past year.

COORDINATING COUNCIL ON MEDICAL EDUCATION

1. Primary Physicians - The CCME and the five parent organizations have approved a policy that fifty percent of graduating students from U.S. medical schools should develop careers in primary care.

2. Foreign Medical Graduates - The CCME has forwarded to the parent organizations a lengthy report and recommendations on foreign medical graduates. The major recommendations are that the exchange visitor program should be restricted to its original intent for graduates of foreign medical schools seeking graduate medical education in the United States by requiring bilateral agreements between the sending country and a U.S. medical school before the visitor is admitted for training. It is also recommended that the waiver provisions be removed for physicians in graduate medical education which currently allow their conversion of an exchange visitor status to a permanent immigrant status without returning to their country of last residence for two years. The parent organizations have not ratified all sections of the report. The Association of American Medical Colleges refused to ratify a section which supported the fifth pathway for U.S. FMGs and added a stipulation that the bilateral agreements for exchange visitors should be between the sending country, a U.S. medical school and an affiliated teaching hospital.

3. Financing Graduate Medical Education - A number of recommendations on future policy for financing graduate medical education under National Health Insurance have been forwarded to the parent organizations. To date, responses to these recommendations have not been received by the CCME. The major thrust of the recommendations is that investment in graduate medical education is a necessary cost of doing business for the Nation's health care system because future physician manpower must be developed continuously in order to provide the health services which the American people will expect from their health care system.

4. Regulation of Residency Positions - Current health manpower legislative debates have focused on the question of regulating available training positions in the various specialties. A section introduced into the House bill, which was removed by floor amendment, would have offered the Coordinating Council on Medical Education the opportunity to assume the responsibility for designating residency positions under the authority of the Secretary of HEW. In the Coordinating Council there was a division of opinion on this provision, with the AAMC strongly supporting the Coordinating Council's assuming the responsibility for residency designation and the four other parent organizations opposing the concept to varying degrees.

LIAISON COMMITTEE ON MEDICAL EDUCATION

The LCME has been working to establish guidelines for the accreditation of medical schools with clinical campuses remote from the main campus of the sponsoring school.

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

1. The LCGME has revised its bylaws to provide for an appeal mechanism for program directors and institutions that desire to appeal adverse decisions by the LCGME. These bylaws are now in the process of being ratified by the parent organizations.

2. A committee of the LCGME/CCME with representatives from the Liaison Committee on Specialty Boards is now reviewing procedures and criteria for recognition of new specialties and the establishment of accreditation programs for training in new specialties. The Executive Council of the AAMC has adopted the position that the final authority for the recognition of a new specialty should be vested in the Coordinating Council.

3. A committee of the LCGME is now rewriting the General Essentials for graduate medical education.

4. A committee of the LCGME is now reviewing the problem of accrediting subspecialty fellowships. This committee's work particularly relates to mounting concerns from internal medicine, pediatrics and other primary boards which provide to individuals recognition of special competence in subspecialty areas.

5. The LCGME is revising the procedures for program review and approval of all Residency Review Committees and will attempt to make these procedures consistent for all RRCs.

LIAISON COMMITTEE ON CONTINUING MEDICAL EDUCATION

This Liaison Committee will hold its first meeting in late November, 1975. It is charged to study and make recommendations on improving continuing medical education and to develop a mechanism for the accreditation of continuing medical education in the United States.

COORDINATING COUNCIL ON MEDICAL EDUCATION

*American Board of Medical Specialties:*

John C. Beck  
Jack D. Myers  
\*John C. Nunemaker  
John F. Roach

*American Hospital Association:*

\*E. Martin Egelston  
\*Madison Brown  
Donald J. Caseley  
H. Robert Cathcart  
David D. Thompson

*American Medical Association:*

Merrill O. Hines, M.D.  
Tom E. Nesbitt  
Bernard J. Pisani  
\*C.H. William Ruhe

*Association of American Medical Colleges:*

William G. Anlyan  
Clifford Grobstein  
John A.D. Cooper  
\*George R. DeMuth

*Council of Medical Specialty Societies:*

C. Rollins Hanlon  
William A. Sodeman  
\*Robert G. Frazier  
\*William C. Stronach  
James G. Price

*Public Member:*

*Federal Government Representative:*

Kenneth M. Endicott

*Ex-Officio, Without Vote:*

Bruce W. Everist  
Joseph M. White  
William D. Holden

\*Staff Member, ex-officio, without vote

Liaison Committee on Medical Education

*Council on Medical Education/AMA:*

Louis W. Burgher  
Bland W. Cannon  
Patrick J.V. Corcoran  
William F. Kellow  
Joseph M. White  
Chris J.D. Zarafonetis  
\*Richard L. Egan  
\*C.H. William Ruhe

*Association of American Medical Colleges:*

Steven C. Beering  
Ralph J. Cazort  
John A.D. Cooper  
Ronald Estabrook  
T. Stewart Hamilton  
Thomas D. Kinney  
C. John Tupper  
James R. Schofield

*Public Member:*

Harriett S. Inskeep  
Arturo G. Ortega

*Federal Government Member:*

\*Staff Member

Liaison Committee on Graduate Medical  
Education

*American Board of Medical Specialties:*

Gordon W. Douglas  
Charles F. Gregory  
William K. Hamilton  
Jack D. Myers  
\*John C. Nunemaker

*American Hospital Association:*

Eugene L. Staples  
Bruce W. Everist, Chairman  
\*Madison Brown  
\*E. Martin Egelston

*American Medical Association:*

Russell S. Fisher  
Gordon H. Smith  
Richard G. Connar  
Richard V. Ebert  
\*Leonard D. Fenninger

*Association of American Medical Colleges:*

\*\*August G. Swanson  
James A. Pittman  
Robert M. Heyssel  
Jack W. Cole

*Council of Medical Specialty Societies:*

Robert G. Fisher  
Edward C. Rosenow  
\*Robert G. Frazier  
\*William C. Stronach

*Public Member:*

O. Meredith Wilson

*Federal Government Representative:*

Robert F. Knouss

*House Staff Representative:*

Jay K. Harness

\*Staff Member, ex-officio, without vote

\*\*Voting Staff Member

Liaison Committee on Continuing Medical  
Education

*American Board of Medical Specialties:*

Saul Farber  
George F. Reed  
Gerald Schenken

*American Hospital Association:*

Donald Cordes  
Harry C.F. Gifford  
Dan G. Kadrovach

*American Medical Association:*

John H. Killough  
Donald Petit  
Charles Verheyden  
J. Jerome Wilgden

*Association of American Medical Colleges:*

Jacob R. Suker  
William D. Mayer  
Richard M. Bergland

*Association for Hospital Medical Education:*

Gail Bank

*Council of Medical Specialty Societies:*

John Connolly  
James Grob  
Charles V. Heck

*Federation of State Medical Boards*

Howard Horns

## CONTINUING MEDICAL EDUCATION

### Relicensure and Recertification

There is a rapid growth of interest in requiring physicians to participate in continuing medical education. State legislatures are moving towards requiring continuing medical education for physicians to maintain licensure. Thus far, the below-named states have set specific requirements:

Arizona	2 days per year
Florida	25 hours per year
Georgia	150 hours every 3 years
Maine	50 hours per year
Maryland	150 hours every 3 years
Michigan	50 hours per year
Nevada	10 hours per year
New Mexico	150 hours every 3 years
Ohio	150 hours every 3 years
Oklahoma	2 days per year
Pennsylvania	150 hours every 3 years
Rhode Island	20 hours per year
Tennessee	150 hours every 3 years
Virginia	50 hours per year
Vermont	2 days per year
West Virginia	2 days per year
Wisconsin	150 hours every 3 years

In at least three states, the licensing board has been empowered to establish requirements for continuing education for maintenance of licensure without specific credit hour requirements. These states are Kentucky, Kansas and Washington. Some state medical associations have made policy decisions which may require continuing education as a condition for membership in the future. These are:

- |            |                  |                   |                 |
|------------|------------------|-------------------|-----------------|
| a) Alabama | d) Kansas        | g) Minnesota      | j) Oregon       |
| b) Arizona | e) Kentucky      | h) New Jersey     | k) Pennsylvania |
| c) Florida | f) Massachusetts | i) North Carolina | l) Vermont      |

The American Board of Family Practice requires recertification for maintenance of recognition as a specialist in Family Practice. The American Board of Internal Medicine has already offered a voluntary recertification exam, and the American Board of Surgery and the American Board of Pediatrics are considering similar voluntary programs. Several Boards are thinking of mandating recertification for future diplomates. The growth of either mandated or seriously encouraged continuing education for U.S. physicians to maintain licensure or specialty recognition is accelerating.

### The Role of the Medical Faculties

This acceleration has implications for the academic medical faculties of the Nation, for the provision of educational services to practicing physicians ultimately devolves on the medical schools and their faculties. If it should occur that all 350,000 physicians in the United States were required to obtain fifty hours of continuing education per year, 17,500,000 contact hours could be needed. The average undergraduate medical student has 1,000 contact hours per year. Thus, a faculty demand equivalent to the establishment of seventeen medical schools could be added to the existing educational load.

Whether faculty input is through participation in lectures and seminars at their schools, at hospital staff meetings in their cities and regions, or at remote meetings at resorts and on cruises, the demand is rapidly increasing the educational responsibilities of the academic community. There are those who believe that continuing education can be accomplished through multimedia and self-instructional materials, but the participation by faculty in producing high-quality moving pictures or slide/tape self-instructional units can be even more time consuming than live lectures and seminars. A major issue, therefore, will be the time demand on the Nation's academic faculty, which is already heavily engaged in undergraduate, graduate education and the provision of educational services to other health professionals in their institutions.

### Relevance

Of equivalent concern is the relevance of the educational services being offered for continuing medical education. The expectation of state legislators appears to be that requiring physicians to attend continuing medical education courses for a specified number of hours will improve medical practice in their states. Committee reports and floor debates in both the Michigan and Ohio legislatures this year indicated that the introduction of continuing medical education requirements is expected to decrease the rate of malpractice litigation. If continuing education is actually to have a direct effect on the quality of medical services provided, and thus improve consumer satisfaction, the conventional approaches to continuing medical education must be assessed to determine if they are likely to have any direct effect on the day-to-day performance of practicing physicians. The small amount of information available in current literature indicates that a direct improvement of practice is hard to demonstrate.

The conventional form of continuing medical education is to provide credit hour recognition to physicians for attending courses given by an institution or agency accredited by the American Medical Association. The criteria for accreditation do not require that the phy-

sicians attending the course be evaluated, either from the standpoint of what they learned or how what they learned was put into practice. During the past several years the American Medical Association has delegated to state medical associations the authority to accredit agencies providing continuing medical education within their states. This means that in at least 40 states, the state medical association is now empowered to approve for continuing medical education credit any institution or organization it chooses.

#### The Liaison Committee on Continuing Medical Education

The Liaison Committee on Continuing Medical Education (LCCME) is now being established under the authority of the Coordinating Council on Medical Education. Its charge is to review present approaches to continuing medical education and recommend changes to improve the education of practicing physicians. Its second charge is to assume responsibility for the accreditation of continuing medical education. Given the development of continuing medical education accreditation thus far, the LCCME will probably have to exert major force to modify the accreditation system and improve the standards for continuing medical education. This may require prolonged effort.

#### AAMC Policy

The AAMC in 1973 adopted the following policy statement for continuing medical education:

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to deliver care to patients throughout their professional lives.*
2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm.*
3. *Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.*

4. *Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice.*
5. *Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.*

### Major Issues

This year finds academic medicine on the threshold of a burgeoning involvement with providing educational services to practicing physicians. The academic community must face several major issues and come to some agreement if continuing medical is to be both relevant to physicians' needs and provideable within the constraints of resources available.

- 1) Should the movement toward relicensure of physicians be supported?
- 2) Should the movement toward recertification by specialty boards be supported?
- 3) Should attendance at short courses provide credit toward relicensure or recertification?
- 4) Should participation in medical audit by individual physicians or groups of physicians become a key requirement in determining relevant educational needs?
- 5) Should regular participation in medical audit tied to an educational program be an alternative to accruing credit hours in short courses?
- 6) Should institutions providing release time to faculty for participation in continuing medical education be reimbursed for the lost faculty services to the institution?

- 7) Should funds for the support of research and development in continuing education in the medical schools be provided? If so, should they be provided through:
  - A. Federal grants and contracts
  - B. State government budgets
    1. derived from general tax revenues
    2. derived from a licensure tax on physicians
  - C. State medical associations
    1. derived from an assessment for continuing education research and development
    2. derived from contributions linked to a lower malpractice insurance rate for those physicians contributing
  - D. Specialty Societies
- 8) Should the medical schools ignore the continuing medical education movement and leave it to private entrepreneurs, state associations and specialty medical societies?
- 9) Should the AAMC and its constituent institutions and organizations develop policies to establish:
  - A. Uniform standards which will make continuing medical education relevant to physicians' specific needs in order to improve their practice of medicine.
  - B. Institutional guidelines for reimbursement for faculty participation in continuing medical education course offerings not sponsored by the medical school.
  - C. Funding policies for research and development in continuing medical education at Federal and State government levels.

## CONFIDENTIALITY OF RESEARCH GRANT PROTOCOLS

The peer review system employed by NIH for awarding grants and contracts is widely recognized as outstanding. The award process has been conducted under rules in which the applications are submitted and reviewed in confidence. This system is now buffeted by a series of post-Watergate waves seeking to insure openness in governmental operation. The Freedom of Information Act (FOIA) of 1967 has been employed by public interest groups seeking to safeguard the rights of children to support their requests for access to grant applications. In a landmark court decision, Judge Gesell agreed that research applications should be made public.

As a result of the Gesell decision, more than 700 requests for applications have now been received by NIH. However, the issue is not simply one of revealing funded grant applications to those who request them but also involves the peer review process, the intellectual property rights of scientists, the protection of human subjects of research, the protection of the public from premature exploitation and the patent rights of individuals. The struggle to resolve these conflicting ideals is far from concluded. Public interest groups continue to seek not only funded grants but all applications and access to study section proceedings as well. In Congress, supporters of complete access threaten additional legislation to compel disclosure of pink sheets and to open all grant review meetings. The AAMC has drafted a position paper dealing with this problem which will be published in Clinical Research in late 1975. Copies of this paper are also available on request.

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

The AAMC has long been engaged with furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This is a response to the National Board of Medical Examiners' Goals and Priorities Committee Report entitled, "Evaluation In The Continuum of Medical Education."

The responses recommended in this document are a consensus derived from a task force report which provided the basis for extensive discussion and debate by the Councils, the Organization of Student Representatives and the Group on Medical Education. The consensus was achieved through deliberation by the Executive Council and is now presented to the Assembly for ratification.

Assuming that the Report of the Goals and Priorities Committee, "Evaluation In The Continuum of Medical Education", has been widely read, an extensive review and analysis is not provided here. The Report recommends that the NBME reorder its examination system. It advises that the Board should abandon its traditional 3 part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the Board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam 'Qualifying A', and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The Committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as Qualifying B. This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: 1) assist individual medical schools in improving their capabilities for intramural assessment of their students; 2) develop methods for evaluating continuing competence of practicing physicians; and, 3) develop evaluation procedures to assess the competence of "new health practitioners."

## RESPONSES

1. *The AAMC believes that the 3 part examination system of the National Board of Medical Examiners should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education.*
2. *The AAMC recommends that the National Board of Medical Examiners should continue to make available examination materials in the disciplines of medicine now covered in Parts I and II of the National Board exams, and further recommends that faculties be encouraged to use these materials as aids in the evaluation of curricula and instructional programs as well as in the evaluation of student achievement.*
3. *The AAMC favors the formation of a qualifying exam, the passing of which will be a necessary, but not necessarily sufficient, qualification for entrance into graduate medical education programs. Passage of Parts I and II of the National Board examination should be accepted as an equivalent qualification.*

The following recommendations pertain to the characteristics and the utilization of the proposed qualifying exam.

- a. *The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed.*
- b. *The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas.*
- c. *The exam should be criterion-referenced rather than norm-referenced.*
- d. *Scores should be reported to the students taking the exam, to the graduate programs designated by such students and to the schools providing undergraduate medical education for such students.*
- e. *The exam should be administered early enough in the students' final year that the results can be transmitted to the program directors without interference with the National Intern and Resident Matching Program.*

- f. *Students failing the exam should be responsible for seeking additional education and study.*
  - g. *Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.*
4. *The AAMC doubts that medical licensure bodies in all jurisdictions will establish a category of licensure limited to practice in a supervised education setting. Therefore, the AAMC recommends that the Liaison Committee on Graduate Medical Education should require that all students entering accredited graduate medical education programs pass the qualifying exam. The LCGME is viewed as the appropriate agency to implement the requirement for such an exam.*
  5. *The AAMC should assume leadership in assisting schools to develop more effective student evaluation methodologies and recommends that the Liaison Committee on Medical Education place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.*
  6. *The AAMC recommends that the LCGME and its parent bodies take leadership in assisting graduate faculties to develop sound methods for evaluating their residents, that each such faculty assume responsibility for periodic evaluation of its residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are ready to be candidates for board exams.*
  7. *The AAMC recommends that physicians should be eligible for full licensure only after the satisfactory completion of the core portion of a graduate medical educational program.*
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#### RECOMMENDATION

The Executive Council recommends that the Assembly approve "The Response of the AAMC to the Principal Recommendations of the Goals and Priorities Committee Report to the National Board of Medical Examiners."

## BORDEN AND FLEXNER AWARDS NOMINATIONS

Last year CAS member societies were encouraged to submit nominees for the Borden Award, which is given by the Association in recognition of outstanding biomedical research. This resulted in an increased number of nominees, with half of the nominations submitted by members of the CAS. The Administrative Board desires to encourage an even greater response this year to the call for Borden Award nominations and, in addition, desires to encourage the CAS member societies to submit nominations for the Flexner Award, which is given in recognition of outstanding contributions to medical education. The regulations governing both awards are shown on the following page. CAS officers and representatives will receive a call for nominations from the Association in March.

## BORDEN AWARD

Nominations for the Borden Award in the Medical Sciences for 1975 are now open.

This award was established by the Borden Company Foundation, Inc. in 1947 and consists of \$1,000 in cash and a gold medal to be granted in recognition of outstanding clinical or laboratory research by a member of the faculty of a medical school which is a member of the Association of American Medical Colleges.

### Regulations Governing the Award

1. Nominations may be made by any member of the faculty of a medical school which is a member of the Association of American Medical Colleges.
2. The Award in any year will be made for research which has been published during the preceding five calendar years.
3. No persons may receive more than one Borden Award for the same research although he/she may receive a later Award for a different research project.
4. If two or more persons who have collaborated on a project are selected for an award, the gold medal and check shall be presented to the group, and bronze replicas of the medal presented to each of the collaborators.
5. The Association may refrain from making an Award in any year in which no person reports research of the quality deserving an Award.
6. Only one Award shall be made during any one year.
7. A nominee who fails to receive the Award may be nominated for the Award for the same work in a subsequent year.
8. Materials supporting a nomination must include:
  - a. Six copies of a statement covering the academic history and scientific accomplishments of the nominee.
  - b. Six copies of a reasoned statement of the basis for the nomination.
  - c. Six copies of reprints reporting the nominee's important research.

## FLEXNER AWARD

The purpose of this memorandum is to request nominations for the 1975 Flexner Award.

In establishing the Abraham Flexner Award for Distinguished Service to Medical Education in 1958, the Association of American Medical Colleges' intent was to recognize extraordinary individual contributions to medical schools and to the medical educational community as a whole.

Previous recipients of this award include:

Lister Hill	Herman G. Weiskotten
Stanley E. Dorst	Alfred N. Richards
James A. Shannon	Joseph C. Hinsey
Joseph T. Wearn	John M. Russell
Ward Darley	Eugene A. Stead, Jr.
Lowell T. Coggeshall	Carl V. Moore
George Packer Berry	William R. Willard
Willard C. Rappleye	George T. Harrell
	John L. Caughey, Jr.

Only one award will be made in one year; any person will be eligible for nomination; and, nominations may be made by any person. Each nomination must be accompanied by seven copies of the nominee's curriculum vitae and seven copies of an appropriate statement of evidence in justification of the nomination.

## INPUT INTO RETREAT AGENDA

During the second week in December, the Chairman and Chairman-Elect of the Councils and the Chairman and Chairman-Elect of the Assembly, will meet with selected AAMC staff to discuss AAMC activities and plan the Association's programs for the coming year. Areas of concern which members of the Council of Academic Societies believe should be called to the attention of the Association officers should be brought up during the discussion of the Retreat Agenda. The Annual Report of the Association, which has been distributed to you, provides information regarding Association activities during the past year.

## COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS

The 93rd Congress created the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1974. Beginning in December, 1974, the Commission has now held 11 two-day sessions. The Commission is composed of 11 members, including biologists, lay representatives, lawyers and ethicists; its Chairman is Kenneth Ryan of Harvard.

The Commission was initially charged to formulate new guidelines for fetal research by May 1, 1975. After several well-publicized and well-attended hearings, the Commission agreed to end the moratorium on fetal research under strict rules governing the research which would be allowed. After considerable debate the Commission forwarded these rules to the Secretary of HEW. The Secretary has now promulgated new regulations almost identical with the Commission's recommendations. These regulations will probably go into effect in November, 1975.

In the past three months the Commission has turned its attention to several new studies which were required by the Congress. They are beginning the study of institutional review boards which review research grant applications for institutional compliance with regulations for the protection of human subjects. The Commission has also begun a study of the ethics of psychosurgery and of ethical guidelines for research in general as well as a series of tours of mental institutions and prisons. These tours are intended to inform the Commissioners about conditions under which research in these populations may possibly be conducted.

All meetings have been open to the public and debates, although occasionally acrimonious, have been consistently high in quality. It is probable that the Commission may become a permanent ethics review panel if legislation now before the Congress is approved.

## AAMC DATA SYSTEMS

For a number of years the AAMC has maintained several data bases which provide information of considerable interest to faculty members and member institutions of the Association. Two of the most useful are the Institutional Profile System (IPS) and the Faculty Roster (FR). The IPS is a comprehensive, flexible, timely and accessible information exchange which is continuously being improved and updated. The system developed in response to needs for obtaining timely information from institutions without continually over-burdening these institutions. The data base now contains in excess of 1,500 data elements describing the U.S. medical school. Although some data is missing, the types of data currently maintained includes faculty, finances, student enrollments, financial aid, federal and other support, primary, ambulatory and family medicine programs, population density by school location, and other information. All of this information is now available for the past three years. In addition, as part of the contract for the President's Biomedical Research Panel, considerable information from NIH files concerning research and training grants, instruction, teaching support, etc. has been added to the data base. A large amount of information obtained annually from the institutions has been added to the data file. Additional data on facilities, curriculum, salaries and hospitals now is being added to the data file.

Individual institutional-sensitive information currently is, and in the future will be, guarded with appropriate passwords. This system, plus the requirement that all access to IPS be approved by the President of AAMC, guarantees confidentiality of sensitive data. Further information on the system may be obtained from Dr. Douglas McRae in the Division of Operational Studies.

The Faculty Roster data system is based on the Faculty Roster Master File. This file has been maintained since 1967 and includes information on more than 50,000 faculty members who are holding, or have held, salaried academic appointment at LCME accredited medical schools in the United States. The instrument used in data collection for the Roster is the Salaried Medical Faculty Questionnaire, a biographical instrument listing 298 data elements which each faculty member fills out at the time of his or her initial appointment. These questionnaires are returned to the AAMC for processing and cooperation has been sufficiently good that the Faculty Roster Master File is now considered to approximate the total population of medical school salaried faculty.

Analyses of data in the Faculty Roster have been carried out by AAMC staff on projects approved by advisory committees and the Executive Staff of the Association. For more information about the Faculty Roster and for information from this source, contact Mr. Thomas Larson, Division of Operational Studies. A number of interesting and useful studies of the characteristics of the U.S. medical school faculty have recently been prepared from these systems and are available upon request.

AAMC/NLM EDUCATIONAL MATERIALS PROJECT  
AAMC DIVISION OF EDUCATIONAL RESOURCES

The Educational Materials Project continuing activities include: the development of a system for the appraisal of educational materials (audio-visual, and evaluation materials, simulations, etc.); the design and implementation of an information system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by users; and approaches to the study of effectiveness of materials. Beginning this year, a concerted effort will be directed toward the formation of standards and procedures regarding the classification and appraisal of computer based educational materials (CBEM). Ultimately, the goal is to make available an evaluated body of health related CBEM which will be organized and regulated to conform to library procedures.

One of the initial tasks undertaken was that of surveying the health professions education faculties in an attempt to ascertain what faculty members have identified as effective educational materials (either self-instructional or lecture support in format), whether they could be made available for panel review and whether they might be available for use by other institutions.

The responses to these queries have identified approximately 8,000 materials. These, added to the materials identified by a survey conducted by the American Association of Dental Schools (AADS) and those previously identified by professional groups and the National Medical Audiovisual Center (NMAC) total approximately 17,000 items which have now been identified for review.

Up to the present time, 36 interdisciplinary panels have been convened to review and appraise educational materials. These panels reviewed materials in the following areas:

neurosciences	oral diagnosis/oral medicine
cardiovascular system	human development
pathology	hematology
periodontics	removable prosthodontics
operative/restorative dentistry	integumentary
fixed prosthodontics	dental materials
behavioral sciences	immune system
musculoskeletal system	infectious diseases
reproductive systems	upper respiratory system
digestive system	anesthesia
orthodontics	rheumatology
pedodontics	occlusion/dental anatomy
respiratory system	pharmacology
oral surgery	histology/cytology
endocrine system	psychiatry/psychology

During these 36 reviews, 4,415 items have been appraised, of which 2,644 have been deemed acceptable for inclusion in the AVLINE data base. A "Highly Recommended" category was achieved by 413 of the accepted items.

The items recommended by the panelists will be included in the National Library of Medicine's data base designated as "AVLINE" which will be available in a format similar to the MEDLINE system. AVLINE was available for testing to selected sites on May 1, 1975. It is anticipated that the system will be fully operational in January, 1976. The process of adding to and updating the AVLINE data base is continuous as the Project seeks to identify, appraise, and make available information about recommended educational materials in the health professions.

Educational Materials Project

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(202) 466-5111

## MEDICAL COLLEGE ADMISSIONS ASSESSMENT PROGRAM

The Association is in the process of revising the Medical College Admissions Test and developing an extensive program for improving the advising of premedical students and the selection of students for entrance into medicine. There are three parts to the program.

### Cognitive Assessment

This is a complete revision of the MCAT. In October of 1974 a contract was given to the American Institutes for Research (AIR) of Palo Alto, California to develop five tests. These are in Analytical Reading, Analysis of Quantitative Information, Biology, Chemistry and Physics. To accomplish this, AIR asked a panel composed of medical educators, physicians and students to rate the elements of knowledge and the skills necessary to enter medical education and to practice medicine. The ratings provided the specifications for the development of the new tests, and from these specifications test items are being produced. By early 1976 the new test forms will undergo preliminary trials and validation studies. The new test will be first administered in the Spring of 1977.

### Noncognitive Assessment

Assisting the medical schools to improve their assessment of the personal qualities of applicants is a major goal of the Medical College Admissions Assessment Program. Many medical schools are now utilizing various instruments for assessing personal qualities but there is no well-organized, systematic approach to the application of these instruments to the selection of potential physicians. The Committee on Admissions Assessment, with the advice of a small working group, has set forth seven personal qualities which should be assessed in selecting students for medical school. Research teams and organizations involved in the development of personality and personal quality assessment instruments were approached to determine their interest in adapting existing test instruments or developing new instruments, to meet the needs of assessing medical school applicants. Four groups have come forward and have been cooperating with the Association staff and the Committee on Admissions Assessment to developing a proposal which will provide a variety of instruments that medical schools can select to utilize depending upon their particular needs. Funding for the development of the non-cognitive section of the assessment program will be sought in the near future.

An initial handbook describing the new testing program has been prepared and distributed to admissions officers, advisors and deans. In 1976 a more detailed handbook will be prepared which will present the test content specifications of the cognitive section and information about the developing non-cognitive test program. Detailed manuals for admissions officers, applicants and advisors, which will facilitate their interpreting the cognitive test results, will be prepared and distributed in early 1977. There will be a national workshop for admissions officers in 1976 to introduce them to the new cognitive assessment battery.

## A STUDY OF THREE-YEAR CURRICULA IN U.S. MEDICAL SCHOOLS

The Division of Educational Measurement and Research, under contract with the Health Resources Administration, Bureau of Health Manpower, Division of Medicine is conducting a study of three-year curricula in U.S. medical schools. The purpose of this study is to provide a description of the changes that were necessary within our institutions that converted from a four-year to a three-year program in undergraduate medical education.

Although the study will gather experimental data regarding all segments of the curricular process, one of the important goals of the project is to reflect the changes required of departmental chairmen and faculty in accomodating a change in the duration of the undergraduate program. We will be particularly interested in the impact of the conversion on: 1) the department chairman's assignment patterns of his faculty to the educational program, 2) the professional task and effort redistribution required of faculty as a result of teaching in a three-year program, and 3) the department chairman's overall administration. In the final analysis, it is extremely important for the study to document and express the concern and experiences of departmental chairmen and faculty who have participated in a three-year program.

Additionally, the study will gather information regarding: 1) the reasons the institution decided to convert to a three-year program and 2) the institutional process through which the conversion was accomplished. Attention will also be directed to gathering considerable data on students participating in three-year programs, i.e., entering profiles, rates of academic progress, and career choice patterns.

An in-depth analysis will be undertaken in approximately nine schools whereas more superficial data will be gathered from all other institutions that have offered three-year programs to their students. The Project staff is making every effort to describe institutional attitudes regarding three-year programs, and thus, welcomes suggestions and input from those involved in undergraduate medical education programs. Suggestions and further information may be obtained from Dr. Robert L. Beran, Project Coordinator, Three-Year Curriculum Study, Division of Educational Measurement and Research, (202) 466-4676.

NATIONAL CITIZENS ADVISORY COMMITTEE  
FOR THE SUPPORT OF MEDICAL EDUCATION

The National Citizens Advisory Committee for the Support of Medical Education has been formed under the leadership of Gustave L. Levy, Chairman, and William Matson Roth, Co-Chairman. Forty-three prominent individuals from across the Nation are members of the Committee, which held its first meeting in New York in mid-September. A Committee Statement on health manpower and federal support for medical education has been issued. The list of the Committee members and the Committee Statement follow.

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STATEMENT BY THE NATIONAL CITIZENS ADVISORY  
COMMITTEE FOR THE SUPPORT OF MEDICAL EDUCATION

Academic medical centers (medical schools and their affiliated teaching hospitals) represent a major national resource for improving the health of our people. They can take great pride in their accomplishments. Biomedical research carried out by their faculties has transformed medicine and made it possible to replace much of the empiricism with effective prevention, diagnosis, and treatment of disease. These advances in medicine have been an important factor in the public's increased desire for more medical services.

Educational programs of the medical schools have prepared physicians and other health professionals to relieve human suffering by the compassionate application of modern medical knowledge. Over the past decade, the medical schools, in response to the need for more physicians, have almost doubled the size of their entering classes. They have moved well along toward their goal of preparing half of the graduates to provide primary care. Medical schools have been largely responsible for developing new health professionals to extend the physician's capacity to render medical care. The teaching hospitals in the medical centers have become essential components of the health care system and provide complex, sophisticated services to all levels of society.

The strengths of American medical schools come from their diversity and freedom in using their distinctive resources in the

most effective way to meet educational, research, and service responsibilities for both the region and the nation. Most of the innovations for improving the maintenance and restoration of health have been developed in this very favorable environment.

Institutional freedom and flexibility will be substantially reduced through requirements in some of the proposals in the Congress for receiving Federal support for medical education on which the institutions have become increasingly dependent. This dependence comes from the growing inadequacy of other sources of support to meet the costs of greater public demand placed on the schools by the scientific and technical advances in medicine which must be incorporated into educational programs and the consequences of spiraling inflation. The proposals require a uniformity of response which would diminish the capability of institutions to employ their resources most effectively in helping solve health care problems.

The responsibility for improving health services must be shared by the practicing profession, by community hospitals, and by private, state, and Federal agencies. The academic medical centers have repeatedly demonstrated their commitment and ability to meet changing needs. However, it must be recognized that all of the deficiencies and inequities in health care cannot be solved by modifications in the education system alone. To impose unrealistic demands on medical centers will reduce the capacity of these institutions to continue their unique contributions,

will divert attention and efforts from seeking more rational solutions through changes in other segments of the health care system, and will bring public disappointment when desired outcomes cannot be achieved.

The Committee is convinced that the medical schools of this Nation should be adequately supported and should be expected to respond to the public need. However, what the schools have done and can do to improve health care in the United States must be objectively assessed and, from this assessment, rational policies for their support must evolve.

#### Aggregate Number of Physicians

One of the requirements for providing accessibility to health care is an adequate number of physicians and other health professionals. In the 1950's, the medical schools recognized that more physicians were needed to meet increasing demands for health care. Efforts at that time to expand class size were impeded by the lack of sufficient financial resources for the task. It was not until 1965 that the Federal Government initiated programs to provide operating support and grants for construction of educational facilities for schools that would meet requirements for enlarging medical school class size. With this assistance, the number of entering medical students was increased from 8,759 in 1965 to nearly 15,000 in 1975. Since it requires about seven years to become fully educated and trained for independent practice, this rapid increase in enrollment is just beginning to be felt in communities. With presently projected expansion, the number of

physicians will reach 200 per 100,000 of population in the 1980's, an increase of one-third over the 1960 level. The United States will continue in the top ranks among all countries of the world in numbers of physicians.

Because of their great expansion over the past decade, many schools do not have the capability to increase class size further and still maintain an adequate level of quality in their educational programs without substantial support for enlarging the faculty and constructing additional educational facilities. In the present economic climate, the required support will be difficult to obtain. Mandatory class size increases to qualify for Federal support will bring even greater fiscal instability for institutions having difficulty in funding ongoing programs.

Recommendations:

The Committee believes that adequate Federal support is essential to permit medical schools to maintain their current levels of enrollment and undertake presently planned voluntary expansion of class size.

Because there is no means of accurately predicting the complex, social, financial, and scientific interactions that will determine the need and demand for medical services in the future, further expansion of class size should not be mandated until the effect of the rapid increase accomplished during the past decade can be assessed.

### Specialty Distribution

There is general agreement that a larger proportion of physicians should be educated and trained in family medicine, general internal medicine, and general pediatrics to provide primary care. Primary care for women is also provided by obstetricians and gynecologists. The Association of American Medical Colleges and other major voluntary medical organizations have adopted a goal of having 50 percent of all students who graduate trained as primary care specialists.

With the growing student interest in primary care, there has been substantial progress in meeting this goal. The main obstacles to complete success are the lack of adequate support for resident training in primary care specialties and the need for appropriate ambulatory settings in which to provide this training.

#### Recommendations:

The Committee believes that the Federal initiatives should be directed toward improving educational programs in ambulatory settings, particularly for primary care specialties. There is a need for substantial support for program costs and construction of facilities if the goal of training 50 percent of students in primary care is to be achieved. Sufficient flexibility in use of funds should be provided so that each school can fashion its response in the

manner most appropriate to its social and geographic environment. Because of the increasing number of graduates of medical schools requiring training, diversion of significant funds from existing hospital-based residency programs for these purposes is not possible.

### Geographic Distribution

Although medical schools can exert considerable influence over the number and specialty distribution of physicians, they have less control over the ultimate practice location of their graduates. Geographic distribution of physicians is dependent on a number of professional, social, and economic factors. No nation in the world, not even the Peoples' Republic of China and the Soviet Union, which exert strong controls over their citizens, has been able to achieve the desired geographic distribution of health professionals.

However, medical schools can make important contributions to the solution of this problem. They can accept a greater proportion of students from underserved areas. It has been shown there is a greater likelihood these students will return to such areas to practice. In addition, schools can work with communities and local agencies and institutions to make the underserved areas more attractive for physicians and to provide a setting for interested students to become aware of opportunities and challenges of practice in these areas.

The National Health Service Corps provides another powerful solution to the maldistribution problem. In return for support in meeting the costs of their medical education, students agree to serve in areas of need designated by the Secretary of Health, Education, and Welfare. In addition to providing health professionals, the Corps also develops the support systems required to deliver modern medical care in these communities. Recruitment to the Corps has been highly successful, and far more students have applied for scholarships than the present level of support can provide.

Requiring medical schools to demand agreements from entering students to practice in underserved areas as a condition for admission introduces a new public policy for universities and their medical schools. The purpose of higher education should not be subordinated to other domestic national purposes which are unrelated to the education process, regardless of the laudability of the objective.

Recommendations:

The Committee concurs with the need to improve the geographic distribution of physicians. It believes that voluntary recruitment to the National Health Service Corps can provide an adequate number of physicians and other health professionals to deliver modern medical care in

underserved areas if the level of funding made available by the Congress matches the established needs.

The Committee believes that requiring mandatory service of all or part of the student body as a direct or implied condition of admission is unwarranted and unnecessary to meet the needs of underserved areas. The admission of students to medical school should be based entirely on the selection of individuals best qualified for careers in medicine. Compulsory obligations for service should not be linked directly or indirectly to decisions concerning admissions to medical schools.

#### Institutional Stability

Academic medical centers have experienced an increasing demand for the provision of more educational and health services without commensurate increases in their support. These demands, coupled with the escalating costs due to inflation and unstable policies for funding biomedical research, have created serious financial instability in these institutions. This instability is forcing management decisions which are not consistent with maintaining or improving the quality of education. Existing programs and plans for new programs--many of which address the major societal problems in health care--are being abandoned or curtailed to make it possible for institutions to survive.

The problem of obtaining adequate support for medical education is not the only source of instability in the academic medical centers. As a result of the complex interrelations among all of the education, research, and service activities carried on in the centers, a decrease in funding of any program will have widespread consequences in the institutions.

The Federal commitment to support medical education was originally based on the concept that the schools and their graduates are a national resource and in recognition of the unavoidable high costs of preparing physicians. In 1971, the Congress requested that the Institute of Medicine of the National Academy of Sciences conduct a study to determine the cost of undergraduate medical education so that the proper Federal share could be determined. However, scant attention has been paid to the study and little use has been made of its recommendations. Furthermore, capitation originally conceived as a means to provide the Federal share of support required for basic ongoing programs is now being utilized to force schools into undertaking new Federal initiatives.

Recommendations:

The Committee urges that stable funding be assured to academic medical centers for the educational, research and health care programs, commensurate with individual institutional capabilities, for solution of the Nation's needs.

The Committee recommends that basic support through capitation be provided based upon an agreed fraction of the cost of undergraduate medical education as determined by the method used by the Institute of Medicine in its study. If political necessity dictates imposing requirements for capitation, sufficient flexibility (as set forth in Senate bill 992) should be provided so that each school can respond in a manner best suited to its goals, resources and environment.

Federal distress grants for institutions with serious financial needs and limited access to other resources should be provided to permit their continued operation and contributions to health care needs.

Funds for special projects to encourage experimentation in more effective and efficient ways to educate health professionals, improve the delivery of health services, and conduct studies on manpower and community and institutional needs should be provided under sufficiently broad authorities to enable each institution to respond in the manner best suited to its goals, resources, and environment. Particular support should be provided for medical schools to work with communities and their health agencies to develop projects targeted at improving the attractiveness of underserved areas so that physicians will choose to locate and serve in those places. Non-federal sources of support for these kinds of activities are extremely limited.

### Student Assistance

The cost of attending medical school is steadily rising. Tuition charges have been increased in an attempt to meet institutional deficits. The cost of living for medical students has followed the general inflationary spiral. Most schools, and particularly new schools, have limited and inadequate resources for student financial aid. However, almost all schools attempt to eliminate financial criteria in selecting medical students so that access to a career in medicine can be provided to the full socioeconomic spectrum of our society. The Federal low-interest-rate student loans, which are administered by the medical schools and which permit students to complete their training before assuming payback obligations, have assisted the schools in adhering to this principle.

Scholarships and grants-in-aid also have been important resources to assure that needy students, particularly those from underrepresented minorities, can enter and complete their medical education. Recently, this form of support has been converted to scholarships requiring a service payback. These voluntary programs for recruiting military and Public Health Service physicians are important resources for students, but they are presently oversubscribed and unavailable for many students who desire to join them.

As class sizes increase and more and more students seek financial aid, larger contributions to loan funds will be needed or the opportunity for medical education will be denied to those in our society who come from the low income strata.

Recommendations:

The Committee believes that a balanced, Federally financed student aid program is essential to assure an opportunity for the best qualified students from all segments of society to become physicians. The programs should include grants-in-aid and low interest loans administered by financial aid officers of the institutions. The level of support should permit the schools to continue to admit students from low income families.

Scholarship programs requiring service in the National Health Service Corps should be increased and form a substantial, but not the entire source of support for students.

Summary

The Committee perceives that dissatisfaction with the health services system of the country is growing rapidly and that the dependence of the medical schools on public support has made them the prime target for those who are impatient at the slowness of the system as a whole to respond. Understandably, there is an urge to move with vigor and dispatch to correct currently perceived deficiencies. But the complex character of the health care system dictates reasonable caution against hurriedly enacted and potentially harmful legislation. While the schools have made important contributions to the solution of health care problems, the limitations of schools to affect the system must be recognized.

The Committee believes strongly that voluntary approaches to problems of national importance are preferable to mandated solutions. Impatience with the slowness of the system as a whole to respond must not lead to the enactment of statutes which will eventually seriously harm the very foundation of excellence for health care in this country, the medical schools and their teaching hospitals. Whatever changes are required in health insurance coverage, in malpractice insurance, and other facets of medical care, the quality of the Nation's medical schools is essential to the maintenance of medical excellence. This quality must not be allowed to deteriorate.

October 16, 1975

## 1976 CAS SPRING MEETING

The Spring Meeting of the Council of Academic Societies will be held in Philadelphia, Pennsylvania. The meeting will be at the Bellevue-Stratford Hotel on March 16, 1976 and will immediately precede the National Board of Medical Examiners Annual Invitational Conference. The NBME this year will focus on "An International View of Qualifications for Medical Practice." The Conference on the 17th and 18th will include speakers from around the world. CAS representatives will be welcome to attend the Invitational Conference.

CAS MEMBERSHIP CHANGES

The Following Societies Have Withdrawn From The CAS:

<u>Name</u>	<u>Date Effective</u>
American Academy of Pediatrics	December, 1975
American College of Psychiatrists	June 17, 1975
American College of Radiology	July, 1975

AAMC Annual Meeting  
COD/CAS/COTH Joint Program  
Wednesday, November 5, 1975  
2:00 p.m. - 5:30 p.m.  
Ballroom Center  
Washington Hilton Hotel

GME PLENARY SESSION  
November 6, 1975  
Ballroom East  
10:00 a.m.

**Title:** "Maximum Disclosure: Individual Rights and Institutional Needs"

**Moderator:** Ivan L. Bennett, Jr., M.D.  
Dean, Vice President for Health Affairs  
and Provost  
New York University  
School of Medicine

**Speakers:** William Smith  
Director, Washington Office  
Washington Research Project-Children's Defense Fund

William P. Gerberding, Ph.D.  
Executive Vice Chancellor  
University of California at Los Angeles

"Remote Site Education: The Case for and the Case Against"

**Presiding:** Christine McGuire  
University of Illinois College of Medicine

**The Case For:** William J. Grov, Executive Dean  
University of Illinois College of Medicine

**The Case Against:** Sherman M. Mellinkoff, Dean  
UCLA School of Medicine

INTERNATIONAL PROGRAM

Monday, November 3  
Lincoln West

8:00pm CHANGING CONCEPTS OF INTERNATIONAL COOPERATION IN HEALTH:  
THE ROLE OF ACADEMIC MEDICAL CENTERS

Moderator: Neal L. Gault, Jr., M.D.

Panel: Carl Taylor, M.D.  
Hector Acuna, M.D.  
James A. Lee, Ph.D.

INTERNATIONAL PROGRAM

Tuesday, November 4  
Hemisphere Room

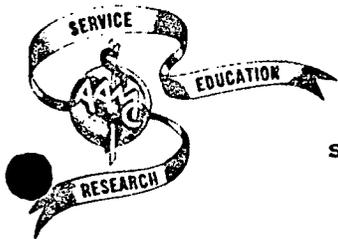
4:30pm-6:00pm

IMPLICATIONS OF THE UNITED KINGDOM'S MERRISON REPORT  
FOR REGULATING MEDICAL PRACTICE AND THE TEACHING OF  
PHYSICIANS

Moderator: William S. Jordan, M.D.

"Implications of the Merrison Report for Medical Practice"  
Sir George Godber, M.B.

"Its Role in Regulating the Teaching of Physicians"  
John R. Ellis, M.D.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

October 22, 1975

M E M O R A N D U M

TO: Council of Academic Societies Representatives

FROM: August G. Swanson, M.D., Director of Academic Affairs 

SUBJECT: AAMC Annual Meeting - Assembly Agenda

The Assembly of the Association is the body which takes final action on major items of Association policy and membership. This year the Assembly is meeting on Tuesday afternoon, November 4, which is the day immediately following the Council of Academic Societies meeting.

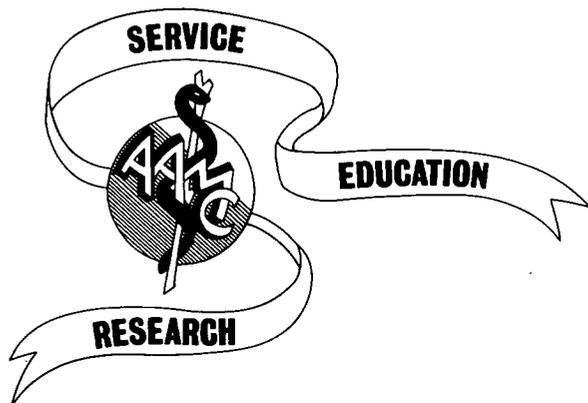
The CAS is entitled to 57 votes in the Assembly, the Council of Teaching Hospitals has an equal number of votes, the Council of Deans has 115 votes and the Organization of Student Representatives has 11.

Items B, C, and D under the Action Items Section of the Agenda are of interest to the CAS. The amendment to the AAMC Bylaws will provide for improvement in representation by the Organization of Student Representatives and also establishes a class of membership of the Council of Teaching Hospitals called "Corresponding Members." The annual dues for corresponding members must also be approved by the Assembly. The Response to the GAP Committee Report of the National Board of Medical Examiners will be acted upon by the Assembly. This will establish Association policy as regards the GAP Report.

It is important that the CAS be represented at the Assembly. One of the representatives from each society is encouraged to attend the Assembly meeting which will be held in the Ballroom East at 1:30 p.m.

Enclosure

AGS/ms



# **AGENDA FOR THE AAMC ASSEMBLY**

November 4, 1975

1:30 – 4:00 p.m.

Washington Hilton Hotel

Washington, D.C.

– Ballroom East –

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

One Dupont Circle

Washington, D.C.

ASSEMBLY AGENDA

November 4, 1975  
1:30 - 4:00 pm

Washington Hilton Hotel  
Washington, D. C.

- Ballroom East -

- I. Call to Order
- II. Quorum Call
- III. Consideration of Minutes of the November 14, 1975 Meeting. . . . . 1
- IV. Report of the Chairman
- V. Report of the President
- VI. Report of the Council of Deans
- VII. Report of the Council of Academic Societies
- VIII. Report of the Council of Teaching Hospitals
- IX. Report of the Secretary-Treasurer
- X. Report of the Organization of Student Representatives
- XI. ACTION ITEMS
  - A. Election of New Members. . . . . 14
    - 1. Institutional Members
    - 2. Provisional Institutional Member
    - 3. Academic Society Members
    - 4. Teaching Hospital Members
    - 5. Individual Members
    - 6. Distinguished Service Members
    - 7. Emeritus Members
  - B. Amendment to AAMC Bylaws . . . . . 23
  - C. Establishment of Annual Dues for Corresponding Members . . . . 33
  - D. The Response of the AAMC to the Principal Recommendations  
of the GAP Committee Report to the NBME. . . . . 34

- XII. Report of the Resolutions Committee
- XIII. Old Business
- XIV. New Business
- XV. Report of the Nominating Committee;  
Election of Officers and New Executive Council Members
- XVI. Installation of Chairman
- XVII. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ASSEMBLY MINUTES

November 14, 1974  
Conrad Hilton Hotel  
Chicago, Illinois

I. Call to Order

The Assembly meeting was called to order by Dr. Daniel C. Tosteson, Chairman, at 1:30 p.m.

II. Declaration of a Quorum

Mr. Robert Derzon, AAMC Secretary-Treasurer, declared the presence of a quorum.

III. Consideration of the Minutes

The minutes of the November 6, 1973 Assembly meeting were approved without change.

IV. Report of the Council of Deans

Dr. Emanuel Papper, Chairman of the Council of Deans, reported that the COD had devoted most of its business meeting to the consideration of Association policy on health manpower legislation. Following a detailed report on the status of current legislative proposals by the AAMC President, Dr. John Cooper, the COD had opened the floor for discussion of the issues by the deans. The ensuing discussion reflected a substantial divergence of opinion as to the role of the federal government in supporting medical education and the role of the medical schools in responding to various legislative requirements.

The COD also heard reports dealing with the Association's response to the National Board of Medical Examiners' GAP Report and on a Coordinating Council on Medical Education paper dealing with foreign medical graduates. The COD did not have time to discuss or take a position on either of these issues.

The COD business meeting concluded with the election of Dr. John Gronvall as Chairman-Elect and Dr. Andrew Hunt as Member-at-Large and with the installation of Dr. Ivan Bennett as Chairman for the upcoming year.

V. Report of the Council of Academic Societies

Dr. Ronald Estabrook, Chairman of the Council of Academic Societies, reported that over the past year the CAS had matured into a cohesive body which can now speak largely with one voice.

The CAS devoted a substantial portion of its business meeting to consideration of the report of the Association's Task Force on the GAP Report, chaired by Dr. Neal Gault. The CAS did not accept the GAP Task Force Report as submitted but endorsed several amendments which will be transmitted to the Executive Council for consideration. The CAS endorsed the GAP Report recommendation that passage of a uniform qualifying examination be required of both domestic and foreign graduates prior to entrance into accredited programs of graduate medical education. However, the CAS believed that the existing 3-part examination system should not be abandoned until an acceptable qualifying examination had been developed and evaluated. The CAS also recommended that the Liaison Committee on Medical Education require for accreditation purposes evidence that the medical school utilizes external evaluation data on the assessment of students with emphasis on the basic sciences.

Following this discussion the CAS addressed the issues surrounding renewal of health manpower legislation. The Council endorsed enthusiastically the following statement of the CAS Administrative Board:

The CAS Administrative Board voted unanimously to recommend that the AAMC be advised of the faculty's concern about the portions of the proposed HPEA bill that constrain and impinge upon the integrity of undergraduate and graduate medical education, even to recommend the defeat of the total bill. The CAS Administrative Board further recommends that every dean and every board of trustees seek every opportunity to obtain funding through alternative means such as tuition increases, increased support from state legislatures, or a decrease in faculty size where necessary to preserve the role of the medical schools in developing and implementing educational programs.

Dr. Estabrook indicated that a continual topic of consideration by the CAS over the past year has been the eroding of basic science support and the related problems of biomedical research and research training. Particular activity has been focused on the evaluation of basic science programs in the accreditation process.

The CAS business meeting concluded with the installation of Dr. Jack Cole as Chairman and the election of Dr. Rolla Hill as Chairman-Elect.

#### VI. Report of the Council of Teaching Hospitals

Mr. Robert Derzon, Chairman of the Council of Teaching Hospitals, reported that the past year had witnessed an expansion in the influence of the COTH and the AAMC in the development of public policy impacting upon the teaching hospitals. Mr. Derzon briefly outlined the activities

of the Council and staff to try to secure appropriate and fair regulations to implement sections of the 1972 Social Security Amendments. Mr. Derzon indicated that the Association's efforts had been fruitful and demonstrated the increasing effectiveness of the Association in representing its teaching hospital members.

Mr. Derzon indicated that the COTH had held four regional meetings over the past year which were both informative and well attended. Annual surveys of university-owned hospital income and expenses and of house staff issues continued. In addition, an examination of the organizational and functional arrangements of computer capabilities in the teaching hospitals has been undertaken.

Mr. Derzon reported that a committee of the COTH had prepared a comprehensive review of the accreditation standards and procedures of the Joint Commission on Accreditation of Hospitals. This study, undertaken at the request of the JCAH, was enthusiastically approved by the Executive Council for transmittal to the Joint Commission.

Support was expressed for the Association's efforts in the area of primary care education and for the Institute on Primary Care held in Chicago the previous month. COTH members indicated that they will participate in the six followup workshops and Mr. Derzon urged the deans and faculty members to become involved. Criteria for membership in the COTH was reported to be the major unresolved issue facing the Council in the upcoming year. The COTH is attempting to reassess the requirement of a substantial commitment to medical education, which is currently evaluated on the basis of the number of residency training programs. The problem arises as a result of medical schools expanding their affiliations with community hospitals, often to provide primary care training opportunities.

Mr. Derzon reported that Mr. Sidney Lewine had been installed as the new COTH Chairman and that Mr. Charles Womer had been elected Chairman-Elect. He concluded his report by expressing the hope that through the AAMC the bond between hospital directors, faculty members and deans would be strengthened.

#### VII. Report of the Organization of Student Representatives

Mr. Daniel Clarke-Pearson, Chairperson of the Organization of Student Representatives, reported that the OSR now had representation from 113 of the 114 medical schools and that 120 students representing 93 medical schools had attended the OSR annual meeting. He indicated that this increase in membership reflected the belief of the medical students that the AAMC is an important force in medical education and health care.

Mr. Clarke-Pearson reported that during the past year the OSR Administrative Board meetings had become synchronized with the Executive Council meetings, so that the OSR Administrative Board was able to review and

make constructive input on the issues before the Executive Council. Of major concern to the OSR was the development of an Association response to the GAP Report. Student viewpoints were consolidated into regional position papers which were then submitted to the AAMC Task Force considering this issue.

As a result of OSR concern with the violations of the code of the National Intern and Resident Matching Program, a monitoring system was activated by which the AAMC would become a conduit for channelling reports of violations to the NIRMP Board of Directors. Mr. Clarke-Pearson indicated that this and other projects had been developed in conjunction with the Group on Student Affairs with whom the OSR meets jointly at the regional level.

Much of the time at the OSR annual meeting was devoted to the consideration of health manpower legislation. The position of the OSR would be discussed in more detail when this issue was discussed later in the agenda.

Mr. Clarke-Pearson concluded by reporting that the OSR had elected Mr. Mark Cannon as Chairperson and Dr. Cynthia Johnson as Vice Chairperson.

#### VIII. Report of the Chairman

Dr. Tosteson outlined the activities of the Executive Council over the past year indicating that, except where immediate action was required, all policy matters were referred to the Administrative Boards of the constituent Councils for discussion and recommendation. Dr. Tosteson reviewed the recommendations of the Officers' Retreat and Executive Council for major areas of activity in 1974. He then outlined the steps which had been taken to implement these recommendations.

The Executive Council approved a report of the Committee on the Financing of Medical Education setting forth the Association position on the roles of the private and public sectors in supporting medical education. The Executive Council also appointed and ultimately approved a report from the Task Force on National Health Insurance chaired by Dr. James Kelly. The policy adopted supported no particular bill but set forth specifications which the Association will support in any pending legislation.

Dr. Tosteson indicated that the Coordinating Council on Medical Education has expanded its activities during the past year, its second year in existence. The Executive Council had approved the first two policy statements to be forwarded by the Coordinating Council to the five parent organizations.

Legal action against the Executive Branch of government over the impoundment of research, research training and health manpower special project funds had been successful. These law suits, which had been filed by the Association prior to the last Assembly meeting, had been

won in both the U.S. District Court and the U.S. Court of Appeals. Following these decisions, the Administration released all funds which had been impounded in these programs. Largely as a result of the Association action and the clear intent of Congress, no significant portion of FY 1975 funds was impounded.

A major policy statement approved by the Executive Council during the past year was the Report of the Task Force on Foreign Medical Graduates. This policy puts the Association on record as favoring a uniform qualifying examination to be required of both U.S. and foreign graduates prior to entering graduate medical education. The thrust of the policy was to subject U.S. and foreign graduates to the same standard of evaluation and to deter the immigration of foreign trained physicians not meeting this minimum standard.

A policy statement on moonlighting by houseofficers was approved, stating that moonlighting is inconsistent with the educational objectives of house officers. The statement continues to say that moonlighting should be an institutional consideration and establishes guidelines which an institution might wish to consider in cases where moonlighting is permitted.

The Executive Council approved the report of its review committee on the Medical College Admission Assessment Program, establishing priorities for the revision of the Medical College Admission Test and for its future expansion into noncognitive areas. The Executive Council approved an increase in the MCAT fee to subsidize this revision.

Dr. Tosteson concluded by reporting that the Executive Committee of the Executive Council had met prior to each Executive Council meeting as well as on numerous occasions throughout the year both in Washington and by conference call. He indicated that the members of the Executive Committee had spent a great deal of time and energy working on behalf of the Association between meetings of the Executive Council. Dr. Tosteson also thanked the staff of the Association for its capable support on behalf of the membership.

#### IX. Report of the President

Dr. Cooper thanked Dr. Tosteson for his great contributions to the Association and his tireless efforts in its behalf over the past year. He indicated that a detailed summary of Association activities over the past year could be found in the 1973-74 Annual Report and went on to highlight a few of these activities.

Dr. John F. Sherman had been appointed by the Executive Council as the first Vice President in the history of the AAMC. Dr. Sherman was familiar to most Association members as a result of his 21-year association with the National Institutes of Health. Dr. Cooper also reported

that Dr. Hilliard Jason had joined the staff to head a new Division of Faculty Development.

Dr. Cooper reported that the Institute on Primary Care had brought together 400 participants, including deans and faculty members of departments of family medicine, internal medicine, pediatrics, obstetrics and gynecology, and psychiatry. The responses to the Institute had been overwhelmingly favorable and six regional workshops will be held in the coming months to examine how individual institutions can respond. Dr. Cooper indicated that support for these efforts was essential since improving the availability of primary care was the number one priority of the federal health policymakers.

Dr. Cooper reported that the Association's staff was undertaking an extensive study of its activities, as well as of income and allocation of funds in order to better plan the long-range development of the AAMC. Since the dues and service fee income is essentially fixed, inflationary pressures have forced the Association to become more dependent on outside sources of support. This review will be carefully monitored by the Executive Council.

Dr. Cooper then turned his attention to some of the immediate problems facing the medical schools and teaching hospitals. Basic research support was diminishing as more federal funds were poured into contract research centers. Requirements being proposed for capitation support threatened to bankrupt the institutions attempting to carry them out. The instability of the schools was reflected by the turnover rate of deans and by the decrease in the number of students selecting careers in academic medicine.

Regulation of the health care industry, characterized by confusing and often conflicting requirements, further adds to the difficulty of coordinating medical center programs and to the instability of the institutions.

The decrease in the average term of accreditation demonstrates the effect which this instability is having on the quality of the educational programs. The rapid increase in enrollments, the inadequacy of financial resources, the turnover in deans and department chairmen, and the dilution of the faculty pool by new schools are all contributing factors.

Further pressures will be felt due to the skyrocketing rate of inflation. Pressures to reduce federal and state spending indicate that the institutions will have to look to other sources to offset these increased costs.

Dr. Cooper concluded by advising that the schools and hospitals take a pragmatic view of the future so that basic and essential programs can be preserved.

X. Report of the Secretary-Treasurer

Alluding to the more detailed report contained in the 1973-74 Annual Report, Mr. Robert Derzon, AAMC Secretary-Treasurer, announced that the Association had completed a successful financial year in which income had exceeded expenditures and commitments. Mr. Derzon reported that the Association's reserves were sufficient to cover approximately six months at the current operating level. He expressed the opinion that this was a modest operating reserve for an association of the size of the AAMC.

ACTION: *On motion, seconded and carried, the Assembly accepted the report of the Secretary-Treasurer.*

XI. Report of the Coordinating Council on Medical Education

Dr. William G. Anlyan, AAMC representative to the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education, reported on the recent activities of those two bodies. He indicated that all five parent organizations had approved the CCME statement on the Responsibility of Institutions, Agencies and Organizations Offering Graduate Medical Education. The parent organizations are currently considering a report on the primary care physician which was forwarded by the CCME.

Dr. Anlyan indicated that a proposal to establish a Liaison Committee on Continuing Medical Education had been approved by four of the five parent organizations and that it was anticipated that the LCCME would become operational in June 1975. Dr. Anlyan also reported that the CCME, pending the approval of the parent organizations, hoped to appeal a decision by the U.S. Office of Education to recognize the Council on Chiropractic Education as an official accrediting agency. This appeal had already been approved by the AAMC Executive Council.

The CCME had approved and would be forwarding to the parent organizations a task force report on the role of foreign medical graduates. Another CCME task force on the financing of graduate medical education has prepared a report which is being revised for CCME and LCGME consideration.

Issues which will be confronting the CCME in the coming year are the staffing of the CCME, the expansion of the LCME and the impact of national health insurance on the continuum of medical education.

The LCGME, pending the approval of DHEW, planned to begin functioning as an accrediting body as of January 1975. Sub-groups of the LCGME would review the Residency Review Committee actions, with each sub-groups being responsible for one or more specialties. Trials of this procedure during the past year proved to be effective.

Beginning in 1975 residency programs will be charged \$300 for accreditation surveys. This charge will cover a portion of the expenses of the survey and review process. The balance of the cost will be covered by the parent organizations of the LCGME.

In concluding, Dr. Anlyan briefly reflected on provisions in the House health manpower bill which would empower the DHEW Secretary to make the CCME responsible for allocating residency training positions among accredited programs.

#### XII. Election of Institutional Members

ACTION: *On motion, seconded and carried, the Assembly elected the following schools to Institutional Membership in the AAMC:*

*University of Massachusetts Medical School  
Worcester, Massachusetts*

*State University of New York  
Stony Brook Medical School*

*Texas Tech University  
School of Medicine*

*University of Texas  
Medical School at Houston*

#### XIII. Election of Provisional Institutional Member

ACTION: *On motion, seconded and carried, the Assembly elected the following school to Provisional Institutional Membership in the AAMC:*

*Wright State University  
School of Medicine*

#### XIV. Election of Academic Society Members

ACTION: *On motion, seconded and carried, the Assembly elected the following societies to Academic Society Membership in the AAMC:*

*Society for Critical Care Medicine*

*Association for Academic Psychiatry*

XV. Election of Teaching Hospitals Members

ACTION: *On motion, seconded and carried, the Assembly elected the following hospitals to Teaching Hospital Membership in the AAMC:*

*Faulkner Hospital  
Boston, Massachusetts*

*Mayaguez Medical Center  
Mayaguez, Puerto Rico*

*McLean Hospital  
Belmont, Massachusetts*

*Memorial Medical Center  
Springfield, Illinois*

XVI. Election of Emeritus Members

ACTION: *On motion, seconded and carried, the Assembly elected the following individuals to Emeritus Membership in the AAMC:*

*Dr. Robert Hanna Felix  
Dr. Walter Campbell MacKenzie*

XVII. Election of Distinguished Service Members

ACTION: *On motion, seconded and carried, the Assembly elected the following individuals to Distinguished Service Membership in the AAMC:*

<i>Dr. Donald Caseley</i>	<i>Dr. John Knowles</i>
<i>Dr. Carleton Chapman</i>	<i>Dr. Robert Marston</i>
<i>Dr. Sam Clark</i>	<i>Mr. Matthew McNulty</i>
<i>Dr. Ludwig Eichna</i>	<i>Dr. Russell Nelson</i>
<i>Dr. Harry Feldman</i>	<i>Dr. John Nurnberger</i>
<i>Dr. Patrick Fitzgerald</i>	<i>Dr. Jonathan Rhoads</i>
<i>Dr. Robert Forster</i>	<i>Dr. David Rogers</i>
<i>Dr. Robert Glaser</i>	<i>Dr. Albert Snoke</i>
<i>Dr. Charles Gregory</i>	<i>Dr. Charles Sprague</i>
<i>Dr. John Hogness</i>	<i>Dr. Robert Stone</i>
<i>Dr. Robert Howard</i>	<i>Dr. Daniel Tosteson</i>
<i>Dr. William Hubbard</i>	<i>Dr. James Warren</i>
<i>Dr. Thomas Hunter</i>	<i>Dr. Ralph Wedgwood</i>
<i>Dr. Thomas Kinney</i>	<i>Dr. William Weil</i>

XVIII. Election of Individual Members

ACTION: *On motion, seconded and carried, the Assembly elected 175 people to Individual Membership in the AAMC.*

XVIX. Amendment of the AAMC Bylaws

The Executive Council had aproved and forwarded to the Assembly a recommendation that the AAMC Bylaws be amended to change the requirement that the Executive Council meet within eight(8) weeks after the annual meeting of the Assembly. It was suggested that this time period be expanded to 120 days. The purpose of this change was to allow more time after the election of new officers for those officers to meet at the Annual Retreat and for the report of that Retreat to be circulated among the Executive Council members.

ACTION: *On motion, seconded and carried, the Assembly voted to amend Title VI, Section 4 of the AAMC Bylaws to read:*

*The annual meeting of the Executive Council shall be held within one hundred twenty (120) days after the annual meeting of the Assembly at such time and place as the Chairman shall determine.*

XX. AAMC Policy on Health Manpower Legislation

Dr. Tosteson reviewed the Association's current policy on health manpower legislation, which was developed by the Executive Council from the recommendations of the Committee on Health Manpower, chaired by Dr. Julius Krevans. The AAMC position supports a continuation of the federal role in providing a stable base of support for medical education in the form of capitation grants. The AAMC position also recognizes the need to respond to problems of geographic and specialty distribution, and supports bonus incentives for projects in these areas. Permeating this policy is the feeling that federal support for medical education should stablize rather than manipulate the educational process. After briefly describing the bills currently pending in Congress, Dr. Tosteson opened the floor for discussion.

The members of the Assembly quickly agreed that a one-year extension of the existing legislation would be desirable, although several members questioned the possibility of Congressional acceptance of an extension. It was generally felt that a thorough reassessment of the AAMC's position could then be conducted, and that there would be no lack of support due to the development of new regulations.

**ACTION:** *On motion, seconded and carried, the Assembly endorsed a recommendation of the Executive Committee that the AAMC support a one-year extension of the Comprehensive Health Manpower Training Act of 1971 and, in the interim, completely reassess its position on renewal of this legislation, possibly through the appointment of a new Task Force reporting to the Executive Council.*

Discussion then turned to how the Association should respond to provisions of the House and Senate bills if an extension of existing legislation was not possible. Several deans recommended that the AAMC oppose on philosophical grounds any federally-mandated requirements for capitation support. Members of the CAS seconded this point of view, emphasizing academic integrity and independence. Other deans argued that the schools should be responsive to Congressional initiatives, and that federal support should not be viewed as an entitlement. Still others felt that the AAMC should act practically, seeking to reduce the number of requirements and to eliminate the most objectionable, while making sure that remaining requirements are adequately funded.

In response to this, Dr. Tosteson read a list of capitation conditions which the Executive Committee had ranked in order of objectionability. The Assembly responded to this listing, again expressing a diversity of viewpoints as to whether the AAMC should accept any prerequisites for basic capitation support.

The OSR Chairperson, indicating that the students had also been divided on this issue, read to the Assembly the position which had been adopted by the OSR:

In recognition of the immediate problems of maldistribution of primary care and the heavy expense of medical education and in order to guarantee our input into the deliberations regarding health manpower legislation which will greatly influence our future careers, the OSR hereby proposes:

1. That programs designed to solve these problems find their base in voluntary action on the part of the medical community;
2. That if obligatory service is to be required, such service should be required of all newly graduating health professionals;
3. That any of the programs must receive adequate financial support.

In addition, the OSR supports the following general statements regarding health manpower legislation:

1. OSR opposes mandatory service by medical students.
2. OSR requests the expansion and improvement of voluntary programs in terms of attractiveness and feasibility.
3. OSR opposes service requirements for a certain fraction of medical students who must accept financial aid in order to obtain medical education due to the discriminatory aspects of such programs.
4. OSR requests that AAMC emphasize the over-subscription to current voluntary programs.
5. OSR requests the increase and improvement of primary care residency opportunities.
6. OSR requests an increase in the time given to primary care training in undergraduate medical education.
7. OSR opposes federal control of specialty residency positions and programs.

Further discussion emphasized the need for the schools to diversify their sources of support. Restrictions imposed by the state governments were also discussed, particularly as they might augment or conflict with federal requirements.

Dr. Tosteson thanked the Assembly members for their input and indicated that their views would be utilized in any reassessment of the Association's position.

XXI. Report of the Resolutions Committee

Dr. Tosteson announced that the Resolutions Committee, chaired by Dr. Robert Van Citters, did not meet because there were no resolutions.

XXII. Report of the Nominating Committee

Mr. George Cartmill, Chairman of the AAMC Nominating Committee for 1974, presented the report of the Nominating Committee which is charged by the AAMC Bylaws with reporting one nominee for the position of

Chairman-Elect and one nominee for each vacancy on the Executive Council. The following slate of nominees was presented:

Chairman-Elect - Leonard W. Cronkhite, Jr., M.D.

Executive Council Members:

COD Representatives - J. Robert Buchanan, M.D.  
Neal L. Gault, Jr., M.D.

CAS Representative - Rolla B. Hill, Jr., M.D.

COTH Representatives- Charles B. Womer  
David D. Thompson, M.D.

Distinguished Service Member - Kenneth R. Crispell, M.D.

*ACTION: On motion, seconded and carried, the Assembly approved the report of the Nominating Committee and elected the individuals listed above to the offices indicated.*

XXIII. Installation of the Chairman

Dr. Tosteson presented the gavel to Dr. Sherman M. Mellinkoff, the new AAMC Chairman. In accepting, Dr. Mellinkoff expressed the Association's appreciation and thanks for Dr. Tosteson's dedicated leadership during his year as Chairman. The Assembly responded with a rising accolade. Dr. Mellinkoff expressed his feeling that as long as the members of the Association stand together and talk with one another that the many difficult and seemingly insoluble problems could be resolved.

XXIV. Adjournment

The Assembly meeting was adjourned at 4:00 p.m.

## ELECTION OF INSTITUTIONAL MEMBERS

The following medical schools have received full accreditation by the Liaison Committee on Medical Education, have graduated a class of students, and are eligible for full Institutional Membership in the AAMC:

University of South Florida  
College of Medicine

Southern Illinois University  
School of Medicine

### RECOMMENDATION

Pending approval by the full Council of Deans, the Executive Council recommends to the Assembly that the schools listed above be elected to Institutional Membership in the AAMC.

ELECTION OF PROVISIONAL INSTITUTIONAL MEMBER

The following school has received a letter of reasonable assurance from the Liaison Committee on Medical Education and is eligible for Provisional Institutional Membership in the AAMC:

University of South Carolina  
School of Medicine

RECOMMENDATION

Pending approval by the full Council of Deans, the Executive Council recommends to the Assembly that the school listed above be elected to Provisional Institutional Membership in the AAMC.

## ELECTION OF CAS MEMBERS

The following Academic Societies are submitted for consideration for election to membership status within the AAMC:

American College of Obstetricians & Gynecologists\*  
American Society of Hematology  
American Society of Plastic & Reconstructive Surgeons  
Association of Medical School Departments of Biochemistry  
Society for Gynecologic Investigation

### RECOMMENDATION

Pending approval by the full Council of Academic Societies, the Executive Council recommends to the Assembly that the societies listed above be elected to Academic Society Membership status in the AAMC.

\*applying for reinstatement in the CAS

ELECTION OF COTH MEMBERS

The following institutions are submitted for consideration for election to membership status within the AAMC:

Crozer-Chester Medical Center  
Chester, Pennsylvania

Lutheran General Hospital  
Park Ridge, Illinois

Memorial Hospital  
Worcester, Massachusetts

RECOMMENDATION

The Executive Council recommends to the Assembly that the hospitals listed above be elected to Teaching Hospital Membership status in the AAMC.

## ELECTION OF INDIVIDUAL MEMBERS

### RECOMMENDATION

The Executive Council recommends to the Assembly the election of the following people to Individual Membership in the AAMC:

George B. Abbott, Jr.  
Alexander Adler  
Gwynn C. Akin\*  
John R. Amberg, M.D.\*  
Harlan C. Amstur  
Albert F. Answini  
Mohamed A. Antar, M.D.  
Marc A. Asher  
Steven T. Ast  
Arthur E. Auer

Henry H. Banks, M.D.  
Alman Barron, Ph.D.  
Jerry A. Bell  
Edwin A. Beller  
Legrand A. Benefiel\*  
James E. Bennett, M.D.  
Julian L. Berman\*  
James Berene, M.D.  
Robert D. Bland  
Wyndham B. Blanton, Jr., M.D.  
Donald F. Brayton  
William P. Bristol, M.D.  
C. Martel Bryant  
Elizabeth A. Burrows, D.O.

Blondel H. Carleton  
Donald M. Cassata  
Geoffrey W. Cates, M.D.  
Marie S. Clabeaux, M.D.  
Robert C. Coddington  
Reginald R. Cooper, M.D.  
Ralph J. Coppola  
Charles D. Corman, Ph.D.  
Marolyn M. Cowart, M.D.  
Girard J. Craft, M.D.  
George E. Cruft, M.D.

Glenn V. Dalrymple, M.D.  
Richard M. Davis, M.D.\*  
Wayne K. Davis, Ph.D.  
Rafael de los Santos  
William M. Deyerle, M.D.  
Everett E. Dodd

Denis J. Donovan, M.D.  
David Dorosin\*  
Fred Dowaliby, Ph.D.

Ian S. Easton  
Merrill T. Eaton, M.D.  
Lois T. Ellison, M.D.  
Harry E. Emson, M.D.  
Vivian Erviti, Ph.D.  
Lloyd R. Evans, M.D.  
Patricia R. Evans  
Daniel E. Everitt

Edward A. Felder, M.D.  
Louis L. Feldman  
Mary A. Ficht  
Donald W. Fisher  
Stanley Fisher  
Frederick T. Fraunfelder, M.D.  
Nat B. Frazer  
Alfred M. Freedman, M.D.  
Henry T. Frierson, Jr.

Donald J. Galagan  
Jorge O. Galante, M.D.  
Richard E. Gallagher\*  
Vincent J. Gebes  
William I. Gefter, M.D.  
Mary C. Gerszewski  
Samuel H. Gilbert  
Ira H. Goodwin  
James W. Graham  
Robert Graham, M.D.  
Robert J. Graham, D.O.  
J. Thomas Grayston, M.D.\*  
Jerome T. Grismer, M.D.  
Leon J. Gross, Ph.D.  
Martin E. Grosse, Ph.D.  
Lawrence J. Guichard  
Edwin R. Guise, Jr., M.D.

Edward T. Habermann, M.D.  
E. David Haigler  
Jack D. Hain, Ph.D.

Nicholas A. Halasz  
Robert G. Harmon  
William L. Hassler  
Henri S. Havdala, M.D.  
Steven D. Helgerson, M.D.  
Leonard Heller, Ed.D.  
Eliot C. Higbee  
Rolla B. Hill, Jr., M.D.  
Franklin T. Hoaglund, M.D.  
William L. Holzemer  
Walter A. Hoyt  
Joseph L. Hozid, Ed.D.  
Richard A. Hubbard II  
E. W. Huffman  
G. Halsey Hunt, M.D.  
David M. Hunter

Thoams W. Johnson, M.D.  
Edward B. Jones  
Charles L. Junkerman

Ronald P. Kaufman, M.D.  
David W. Kennard  
Dudley C. Kenworthy  
Lawrence M. Klainer, M.D.  
James K. Knoble\*  
Joseph A. Kopta, M.D.

Peter A. Lake, M.D.  
Raynald A. Lane, M.D.  
Lars W. Larson  
Thomas P. Layloff, Jr.  
Martha Leape  
Lloyd A. Lewis  
Karen G. Lichter  
James Lieberman  
Joseph W. Linhart, M.D.  
Jerome P. Lysaught\*

David H. MacInnes  
Winton H. Manning  
R. L. Matkin  
Margie R. Matthews  
Harold Mazur, M.D.\*

Susan J. Mellette  
Susan Meunier  
Elizabeth A. Meyer  
Thomas L. Meyer  
Don R. Miller

Richard C. Miller, M.D.  
Stephen H. Miller, M.D.

David G. Murray, M.D.  
John G. Murray

Carl L. Nelson, M.D.  
Elof G. Nelson, Ph.D.  
Jesus B. Nolasco

Sally L. Olexia

Robert C. Parlett, M.D.  
R. Gibson Parrish, M.D.  
Edmund D. Pellegrino, M.D.\*  
Deagelia M. Pena  
Lysle H. Peterson  
Alexander W. Pierce, Jr., M.D.  
Milton Potash  
Thomas S. Powell  
Joe T. Powell  
Donald V. Powers, M.D.

Oscar N. Rambo, M.D.  
Lloyd F. Redick, M.D.\*  
Robert C. Ripley  
Elzey M. Roberts  
Charles A. Rockwood, Jr., M.D.  
C. A. Rodowskas, Jr.  
Sheldon N. Rose  
Joseph J. Rovinsky  
Lester A. Russin

Joseph F. Salerno  
Thomas Samph, Ph.D.  
Ruth Scheuer  
David C. Schmauss  
Terry L. Schmidt  
Julian B. Schorr  
Stuart H. Shapiro, M.D.  
Eleanor G. Shore, M.D.  
David L. Silver, M.D.  
Martin E. Silverstein, M.D.  
Wayne O. Southwick  
George E. Spencer, M.D.  
Harold E. Springer  
Timothy A. Stabler  
Robin C. Stark  
Bessie A. Stein  
Peter Stewart II

William R. Storer, M.D.  
Wilbur H. Stover  
Ruth H. Strang\*  
James N. Sussex, M.D.  
Alfred B. Swanson, M.D.  
Francis J. Sweeney, Jr., M.D.

Lawrence T. Taft, M.D.  
Bernice A. Thieblot  
Dola S. Thompson, M.D.  
Samir I. Toubassy  
Eugene J. Towbin, M.D.  
John E. Trufant  
John M. Tudor, M.D.

H. Mac Vandiviere, M.D.  
Frank R. Vitale

James J. Watrous  
Theodore R. Waugh, M.D.  
Barbara H. Way, M.D.

Herbert D. Weintraub  
William D. Weitzel  
George W. Wermers  
Storm Whaley  
Thomas E. Whitesides, Jr., M.D.  
Ronald Winter  
Barbara J. Woods

Asa G. Yancey, M.D.  
David P. Youel, M.D.

Antonio Zappala

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\*denotes persons formerly holding Individual Membership

ELECTION OF DISTINGUISHED SERVICE MEMBERS

The Council of Deans has submitted the following individuals for consideration for election to membership status within the AAMC:

George N. Aagaard  
Donald G. Anderson  
Clifford G. Grulee  
Leon O. Jacobson  
William Mayer  
Stanley Olson  
Lewis Thomas

RECOMMENDATION

The Executive Council recommends to the Assembly that the individuals listed above be elected to Distinguished Service Membership status in the AAMC.

## ELECTION OF EMERITUS MEMBERS

The Bylaws of the Association establish the following criteria for Emeritus Membership:

Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.

In addition, five specific criteria were established by the Executive Council at its September 1971 meeting:

1. Emeritus membership be restricted to those members who have become emeritus members of the faculty or have reached retirement age in their organization.
2. To be eligible, the individual should have established a national and/or international reputation in medical education.
3. He/She should have given outstanding service to the Association through membership on its councils, committees, or task forces.
4. The individual at the time of his/her nomination should either be an individual member of the Association or should have served as an institutional representative, a representative of one of the academic societies, or a teaching hospital member.
5. Sufficient information should be provided on the nominee to permit the Executive Council to determine whether he/she fits the above criteria for membership.

Nominations for Emeritus Membership have been solicited and the following names are presented for consideration:

John L. Caughey, Jr.  
Thomas Hale Ham  
John P. Hubbard

Leland E. Powers  
Lamar Soutter  
Harold C. Wiggers

### RECOMMENDATION

The Executive Council approved the election to Emeritus Membership of the individuals listed above and recommends their election to the Assembly.

## AMENDMENT TO AAMC BYLAWS

The Executive Council has recommended to the Assembly the adoption of several amendments to the AAMC Bylaws, a current copy of which appears on the following pages. These amendments have been proposed to achieve two specific purposes.

1. The COTH Ad Hoc Membership Committee recommended that a mechanism be provided for membership in the AAMC of hospitals which are involved in medical education but which do not meet the criteria for COTH membership. It was felt that the establishment of a new category of Corresponding Membership in the Association would be preferable to weakening the criteria for membership in COTH (which now require that a hospital have at least four approved residency programs, among other specific criteria). The Executive Council agreed with this proposal and recommends to the Assembly the amendments to the Bylaws necessary to establish a category of "Corresponding Members."
2. The OSR and COD Administrative Boards requested that the Bylaws be amended to allow the continued participation of OSR Administrative Board members who, because of mid-year elections or graduation, no longer serve as the primary representative of their school to the OSR. The amendment is necessary because no individual can sit on an Association governing board except in the capacity of representing his/her institution. Several corresponding modifications of the OSR Rules and Regulations have been approved by the OSR and COD Administrative Boards to be consistent with this proposed Bylaws change.

### PROPOSED AMENDMENTS

Add to Title I, Section 1:

#### I. Corresponding Members

Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Add to Title I, Section 3:

- F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

Add the italicized language, as it appears below, to Title III:

There shall be an Organization of Student Representatives related to the Council of Deans, operated in a manner consistent with rules and regulations approved by the Council of Deans and comprised of one representative of each institutional member that is a member of the Council of Deans chosen from the student body of each such member. *Institutional members whose representatives serve on the Organization of Student Representatives Administrative Board may designate two representatives on the Organization of Student Representatives, provided that only one representative of any institutional member may vote in any meeting.* The Organization of Student Representatives shall meet at least once each year at the time and place of the annual meeting of the Council of Deans in conjunction with said meeting to elect a Chairman and other officers, to recommend student members of committees of the Association, to recommend to the Council of Deans the Organization's representatives to the Assembly, and to consider other matters of particular interest to students of institutional members. All actions taken and recommendations made by the Organization of Student Representatives shall be reported to the Chairman of the Council of Deans.

#### RECOMMENDATION

The Executive Council recommends that the Assembly approve the amendments to the AAMC Bylaws proposed above.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

BYLAWS

I. MEMBERSHIP

Section 1. There shall be the following classes of members, each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:

- A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.
- B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.
- C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.
- D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.
- E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.
- F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.
- G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.
- H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.

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Section 2. There shall also be the following classes of honorary members who shall meet the criteria therefore established by the Executive Council:

- A. Emeritus Members - Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.
- B. Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.
- C. Individual Members - Individual Members shall be persons who have demonstrated a serious interest in medical education.
- D. Sustaining and Contributing Members - Sustaining and Contributing Members shall be persons or corporations who have demonstrated over a period of years a serious interest in medical education.

Section 3. Election to membership:

- A. All classes of members shall be elected by the Assembly by a majority vote on recommendation of the Executive Council.
- B. All institutional members will be recommended by the Council of Deans to the Executive Council.
- C. Academic society members will be recommended by the Council of Academic Societies to the Executive Council.
- D. Teaching hospital members will be recommended by the Council of Teaching Hospitals to the Executive Council.
- E. Distinguished service members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

Section 4. Revocation of Membership - A member with any class of membership may have his membership revoked by a two-thirds affirmative vote of the Assembly on recommendation with justification by the Executive Council; provided that the Executive Council shall have given the members written notice of the proposed revocation prior to the Assembly at which such a vote is taken.

Section 5. Resignation - A member with any class of membership may resign upon notice given in writing to the Executive Council. However, any such resignation shall not be effective until the end of the fiscal year in which it is given.

## II. COUNCILS

Section 1. There shall be the following Councils of the Association each of which shall be governed by an Administrative Board and each of which shall be organized and operated in a manner consistent with rules and regulations approved by the Executive Council:

- A. Council of Deans - The Council of Deans shall consist of the Dean or the equivalent academic officer of each institutional member and each provisional institutional member that has admitted its first class of students.
- B. Council of Academic Societies - The Council of Academic Societies shall consist of two representatives from each academic society member who shall be designated by each such member for a term of two years.
- C. Council of Teaching Hospitals - The Council of Teaching Hospitals shall consist of one representative from each teaching hospital member who shall be designated annually by each such member.

## III. ORGANIZATION OF STUDENT REPRESENTATIVES

There shall be an Organization of Student Representatives related to the Council of Deans, operated in a manner consistent with rules and regulations approved by the Council of Deans and comprised of one representative of each institutional member that is a member of the Council of Deans chosen from the student body of each such member. The Organization of Student Representatives shall meet at least once each year at the time and place of the annual meeting of the Council of Deans in conjunction with said meeting to elect a Chairman and other officers, to recommend student members of committees of the Association, to recommend to the Council of Deans the Organization's representatives to the Assembly, and to consider other matters of particular interest to students of institutional members. All actions taken and recommendations made by the Organization of Student Representatives shall be reported to the Chairman of the Council of Deans.

## IV. MEETINGS OF MEMBERS AND COUNCILS

Section 1. Meetings of members of the Association shall be known as the Assembly. An annual Assembly shall be held at such time in each October or November and at such place as the Executive Council may designate.

Section 2. Special meetings of the Assembly may be called for any purpose by the Chairman, by a majority of the voting members of the Executive Council, or by twenty voting members of the Association.

Section 3. All meetings of the Assembly shall be held at such place in Illinois, the District of Columbia or elsewhere as may be designated in the notice of the meeting. Written or printed notice stating the place, day and hour of the meeting and, in case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than five nor more than forty days before the date of the meeting, either personally or by mail, by or at the direction of the Chairman or persons calling the meeting, to each member entitled to vote at such meeting.

Section 4. The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the Council of Deans and a number of members of the Organization of Student Representatives equivalent to 10 percent of the members of the Association having representatives in said Organization. Each of such representatives of Institutional Members and Provisional Institutional Members that have admitted their first class shall have the privileges of the floor in all discussions and shall be entitled to vote at all meetings. The Council of Academic Societies and the Council of Teaching Hospitals each shall designate a number of their respective members as members of the Assembly, each of whom shall have one vote in the Assembly, the number from each Council not to exceed one-half the number of members of the Council of Deans entitled to vote. All other members shall have the privileges of the floor in all discussions but not be entitled to vote at any meeting.

Section 5. A representative of each voting member shall cast its vote. The Chairman may accept the written statement of the Dean of an institutional member, or provisional institutional member, that he or some other person has been properly designated to vote on behalf of the institution, and may accept the written statement of the respective Chairmen of the Council of Academic Societies and the Council of Teaching Hospitals designating the names of individuals who will vote on behalf of each member society or hospital. The Chairman may accept the written statement of the Chairman of the Council of Deans reporting the names of the individuals who will vote as the representatives chosen by the Organization of Student Representatives.

Section 6. One-third of the voting members of the Association shall constitute a quorum at the Assembly. Except as otherwise provided herein, action at any meeting shall be by majority vote at a meeting at which a quorum is present, provided that if less than a quorum be present at any meeting, a majority of those present may adjourn the meeting from time to time without further notice.

Section 7. Each Council of the Association shall meet at least once each year at such time and place as shall be determined by its bylaws and designated in the notice thereof for the purpose of electing members of the Administrative Board and officers.

Section 8. Regional meetings of each Council may be held in each of the geographical regions established by the Executive Council for the purpose of identifying, defining and discussing issues relating to medical education and in order to make recommendations for further action at the national level. Such meetings of each Council shall be held at such time and place as deter-

mined in accordance with procedures approved by the Executive Council.

Section 9. No action of the Association shall be construed as committing any member to the Association's position on any issue.

Section 10. Robert's Rules of Order, latest edition, shall govern all meetings.

#### V. OFFICERS

The officers of the Association shall be those elected by the Assembly and those appointed by the Executive Council.

Section 1. The elected officers shall be a Chairman, who shall preside over the Assembly and shall serve as Chairman of the Executive Council, and a Chairman-Elect, who shall serve as Chairman in the absence of the Chairman. The Chairman-Elect shall be elected at the annual meeting of the Assembly, to serve in that office for one year, and shall then be installed as Chairman for a one-year term in the course of the annual meeting of the Assembly the year after he has been elected. If the Chairman dies, resigns, or for any other reason ceases to act, the Chairman-Elect shall thereby become Chairman and shall serve for the remainder of that term and the next term.

Section 2. The officers appointed by the Executive Council shall be a President, who shall be the Chief Executive Officer, a Vice President, a Secretary and a Treasurer, who shall be appointed from among the Executive Council members. The Executive Council may appoint one or more additional officers on nomination by the President.

Section 3. The elected officers shall have such duties as are implied by their title or are assigned to them by the Assembly. The appointed officers shall have such duties as are implied by their titled or are assigned to them by the Executive Council.

#### VI. EXECUTIVE COUNCIL

Section 1. The Executive Council is the Board of Directors of the Association and shall manage its affairs. The Executive Council shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law and the Bylaws. It shall carry out the policies established at the meetings of the Assembly and take necessary interim action for the Association and carry out duties and functions delegated to it by the Assembly. It shall set educational standards and criteria as prerequisites for the elections of members of the Association, it shall consider applications for membership and it shall report its finding and recommendations with respect thereto to the Assembly.

Section 2. The Executive Council shall consist of fifteen members elected by

the Assembly and ex officio, the Chairman, Chairman-Elect, President, the Chairman of each of the three councils created by these Bylaws, and the Chairman of the Organization of Student Representatives, all of whom shall be voting members. Of the fifteen members of the Executive Council elected by the Assembly, three shall be members of the Council of Academic Societies, three shall be members of the Council of Teaching Hospitals; eight shall be members of the Council of Deans, and one shall be a Distinguished Service Member. The elected members of the Executive Council shall be elected by the Assembly at its annual meeting, each to serve for three years or until the election and installation of his successor. Each shall be eligible for re-election for one additional consecutive term of three years. Each shall be elected by majority vote and may be removed by a vote of two-thirds of the members of the Assembly present and voting.

Section 3. At least one elected member of the Executive Council shall be from each of the regions of the Association.

Section 4. The annual meeting of the Executive Council shall be held within eight (8) weeks after the annual meeting of the Assembly at such time and place as the Chairman shall determine.

Section 5. Special meetings of the Council may be called by the Chairman or any two (2) Council members, and written notice of all Council meetings, unless waived, shall be mailed to each Council member at his home or usual business address not later than the tenth business day before the meeting.

Section 6. A quorum of the Council shall be a majority of the voting Council members.

Section 7. In the event of a vacancy on the Executive Council, the remaining members of the Council may appoint a successor to complete the unexpired term. Appointed members may not serve more than two consecutive full terms on the Council following appointment to an unexpired term. The Council is authorized at its own discretion to leave a vacancy unfilled until the next annual meeting of the Assembly.

## VII. COMMITTEES

Section 1. The Chairman shall appoint from the Assembly a Resolutions Committee which shall be comprised of at least one representative from each Council of the Association and from the Organization of Student Representatives. The Resolutions Committee shall present resolutions to the Assembly for action by it. No resolution shall be considered for presentation by the Resolutions Committee unless it shall have been received at the principal office of the Association at least fourteen days prior to the meeting at which it is to be considered. Additional resolutions may be considered by the Assembly upon a two-thirds vote of the members of the Assembly present and voting.

Section 2. The Executive Council shall appoint the Chairman and a Nominating

Committee of not less than four nor more than six additional members, including the Chairman of the Nominating Committee of each of the Councils provided in Paragraph II. The Nominating Committee so appointed will report to the Assembly at its annual meeting one nominee for each officer and member of the Executive Council to be elected. Additional nominees for any officer or member of the Executive Council may be made by the representative of any member of the Assembly. Election shall be by a majority of the Assembly members present and voting.

Section 3. The Executive Council, by resolution adopted by the vote of a majority of the voting Council members in office, may designate an Executive Committee to act during intervals between meetings of the Council, consisting of the Chairman, the Chairman-Elect, the treasurer, the President, and three or more other Council members, which committee, to the extent provided in the resolution, shall have and exercise the authority of the Council in the management of the Association. At all times the Executive Committee shall include at least one member of each of the Councils provided in Paragraph II hereof. The designation of such a committee and the delegation to it of authority shall not relieve the Council, or any members of the Council, of any responsibility imposed upon them by law.

Section 4. The Executive Council may appoint and dissolve from time to time such standing or ad hoc committees as it deems advisable, and each committee shall exercise such powers and perform such duties as may be conferred upon it by the Executive Council subject to its continuing direction and control. The Chairman will appoint members of the committees with appropriate consultation with the Executive Council.

#### VIII. GENERAL PROVISIONS

Section 1. Whenever any notice whatever is required to be given under the provisions of these Bylaws, a waiver thereof in writing signed by the persons entitled to such a notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

Section 2. The Council may adopt a seal for the Association, but no seal shall be necessary to take or to evidence any Association action.

Section 3. The fiscal year of the Association shall be from each July 1 to June 30.

Section 4. The annual dues of each class of members shall be in such amounts as shall be recommended by the Executive Council and established by the Assembly. The Executive Council shall consult with the respective administrative boards of the Council of Deans, the Council of Academic Societies and the Council of Teaching Hospitals in arriving at its recommendations.

Section 5. Any action that may be taken at a meeting of members or of the

Executive Council may be taken without a meeting if a consent in writing setting forth the action so taken is signed by all members of the Association entitled to vote with respect to the subject matter thereof, or by all members of the Executive Council as the case may be.

Section 6. No part of the net earnings of the Association shall inure to the benefit of or be distributable to its members or members of the Executive Council, officers, or private individuals, except that the Association may pay reasonable compensation for services rendered and make payment and distributions in furtherance of its purposes. No substantial part of the activities of the corporation shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the Association shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these articles, the Association shall not carry on any activities not permitted to be carried on (a) by an organization exempt from Federal income tax under Section 501 (a) as an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by an organization, contributions to which are deductible under Section 170 (c) (2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

Section 7. Upon dissolution of the corporation, the Executive Council shall, after paying or making provision for the payment of all of the liabilities of the Association (including provision of a reasonable separation pay for its employees), dispose of all of the assets of the Association among such non-profit organizations having similar aims and objectives as shall qualify as exempt organizations described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provisions of any future United States Internal Revenue Law).

Section 8. These Bylaws may be amended by a two-thirds vote of the voting members present and voting at any duly called meeting of the Assembly, provided that the substance of the proposed amendment is included with the notice of the meeting. Amendments to the Blaws may be proposed by the Executive Council or by the written sponsorship of ten voting members, provided that the proposed amendment shall have been received by the Secretary at least forty-five days prior to the meeting at which it is to be considered.

ESTABLISHMENT OF ANNUAL DUES  
FOR CORRESPONDING MEMBERS

If the Assembly approves the proposed amendment to the AAMC Bylaws establishing a category of Corresponding Members, it will be necessary to establish the annual dues for this category of membership. The Executive Council has proposed that Corresponding Members receive many of the benefits of membership in the Association, such as the President's Weekly Activities Report, the Journal of Medical Education, the COTH Report, all memoranda of interest to the hospitals, and other appropriate communications.

RECOMMENDATION

The Executive Council recommends to the Assembly the establishment of annual dues for Corresponding Members at a rate of \$500.

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

The AAMC has long been engaged with furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This is a response to the National Board of Medical Examiners' Goals and Priorities Committee Report entitled, "Evaluation In The Continuum of Medical Education."

The responses recommended in this document are a consensus derived from a task force report which provided the basis for extensive discussion and debate by the Councils, the Organization of Student Representatives and the Group on Medical Education. The consensus was achieved through deliberation by the Executive Council and is now presented to the Assembly for ratification.

Assuming that the Report of the Goals and Priorities Committee, "Evaluation In The Continuum of Medical Education", has been widely read, an extensive review and analysis is not provided here. The Report recommends that the NBME reorder its examination system. It advises that the Board should abandon its traditional 3 part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the Board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam 'Qualifying A', and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The Committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as Qualifying B. This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: 1) assist individual medical schools in improving their capabilities for intramural assessment of their students; 2) develop methods for evaluating continuing competence of practicing physicians; and, 3) develop evaluation procedures to assess the competence of "new health practitioners."

## RESPONSES

1. *The AAMC believes that the 3 part examination system of the National Board of Medical Examiners should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school students and graduates in both the basic and clinical science aspects of medical education.*

2. *The AAMC recommends that the National Board of Medical Examiners should continue to make available examination materials in the disciplines of medicine now covered in Parts I and II of the National Board exams, and further recommends that faculties be encouraged to use these materials as aids in the evaluation of curricula and instructional programs as well as in the evaluation of student achievement.*

3. *The AAMC favors the formation of a qualifying exam, the passing of which will be a necessary, but not necessarily sufficient, qualification for entrance into graduate medical education programs. Passage of Parts I and II of the National Board examination should be accepted as an equivalent qualification.*

The following recommendations pertain to the characteristics and the utilization of the proposed qualifying exam.

- a. *The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed.*
- b. *The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas.*
- c. *The exam should be criterion-referenced rather than norm-referenced.*
- d. *Scores should be reported to the students taking the exam, to the graduate programs designated by such students and to the schools providing undergraduate medical education for such students.*
- e. *The exam should be administered early enough in the students' final year that the results can be transmitted to the program directors without interference with the National Intern and Resident Matching Program.*
- f. *Students failing the exam should be responsible for seeking additional education and study.*
- g. *Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.*

4. The AAMC doubts that medical licensure bodies in all jurisdictions will establish a category of licensure limited to practice in a supervised education setting. Therefore, the AAMC recommends that the Liaison Committee on Graduate Medical Education should require that all students entering accredited graduate medical education programs pass the qualifying exam. The LCGME is viewed as the appropriate agency to implement the requirement for such an exam.

5. The AAMC should assume leadership in assisting schools to develop more effective student evaluation methodologies and recommends that the Liaison Committee on Medical Education place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

6. The AAMC recommends that the LCGME and its parent bodies take leadership in assisting graduate faculties to develop sound methods for evaluating their residents, that each such faculty assume responsibility for periodic evaluation of its residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are ready to be candidates for board exams.

7. The AAMC recommends that physicians should be eligible for full licensure only after the satisfactory completion of the core portion of a graduate medical educational program.

#### RECOMMENDATION

The Executive Council recommends that the Assembly approve "The Response of the AAMC to the Principal Recommendations of the Goals and Priorities Committee Report to the National Board of Medical Examiners."