AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Monday, November 7, 1977

1:30 p.m. - 6:00 p.m.

Washington Hilton Hotel
Lincoln East & West
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C. 20036

AAMC ANNUAL MEETING

November 6-10, 1977 — Washington, D.C.

1978 MEETING DATES

CAS Administrative Board Meetings
January 18-19, 1978
March 22-23, 1978
June 21-22, 1978
September 13-14, 1978
— Washington, D.C.

CAS Interim Meeting

January 18, 1978 — Washington, D.C.

AAMC ANNUAL MEETING

October 22-26, 1978 — New Orleans, Louisiana

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

Monday, November 7, 1977
1:30 pm - 6:00 pm
Lincoln East & West Room
Washington Hilton Hotel
Washington, D.C.

Continued . . .

VII. NEW BUSINESS

5:00 p.m. Announcement of Election Results

VIII. "The Food and Drug Administration and the Academic Medical Centers"

Donald Kennedy, Ph.D., Commissioner, Food and Drug Administration

6:00 p.m. Adjourn

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

November 12, 1976

San Francisco Hilton Hotel
San Francisco, California

I. Call to Order

The meeting was called to order at 9 a.m. Dr. Rolla B. Hill, Jr., Chairman, presided. Fifty-five individuals, representing 44 of the 59 member societies, were present. Societies not represented were:

American Association for the Study of Liver Diseases
American Society for Clinical Investigation, Inc.
Central Society for Clinical Research
Southern Society for Clinical Investigation
Society of Critical Care Medicine
Association of Professors of Medicine
Association of University Professors of Ophthalmology
Association of Pathology Chairmen, Inc.
American Pediatric Society
Association for Medical School Pharmacology
Association of Academic Physiatrists
Association of Teachers of Preventive Medicine
American Society of Therapeutic Radiologists
Society of Surgical Chairmen
Society of University Surgeons

II. Approval of Minutes

The minutes of the meeting held November 3, 1975 were approved as circulated.

III. Chairman's Report - Rolla B. Hill, Jr.

The full text of the Chairman's Report is appended to these minutes.

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

The program activities of the Association for 1976 were delineated in the AAMC Annual Report distributed to all registrants at the AAMC Annual Meeting. Additionally, a summary of these activities was prepared especially for the Council of Academic Societies and circulated to the membership during the CAS Business Meeting. This seven-page summary was prepared to assist CAS

official representatives in reporting the scope of AAMC programs to the membership of their societies. It will be incorporated in the CAS Directory which will be circulated to members early in 1977.

Dr. Cooper welcomed the new members of the Council of Academic Societies. He said that the CAS has matured during the period of time that faculty have been involved in developing policy and programs in AAMC. They have made some very important contributions to the overall activities of the Association and, he added, he looks forward to their increased involvement in the future. More and more difficult times, he predicted, are ahead as an attempt is made to maintain some of the very essential features of the university which are critical not only to the welfare of the academic community but also to the welfare of the public.

The intrusion of the federal sector into the private sector is demonstrated by the growth in size of the Federal Register, the document in which all rules and regulations to implement not only legislation but also Executive actions are published. According to AAMC figures, the Federal Register grew in one year from 35,000 to 45,000 pages.

Highlighting some areas of current concern, Dr. Cooper spoke of several matters:

A. Federal Trade Commission Challenges LCME

The Federal Trade Commission recently filed a letter with the U.S. Commissioner of Education, HEW, asking that he deny recognition of the Liaison Committee on Medical Education as the accrediting agency for U.S. medical schools. Under provisions of the Public Health Service Act, only those institutions accredited by an agency recognized by the Commissioner of Education are eligible to receive federal funds. The LCME's previous recognition, granted in 1972, comes up for renewal in December. The LCME, which has accredited medical schools in the U.S. and Canada since 1942, is composed of six AAMC appointees, six AMA appointees, two public representatives, and one federal member.

The FTC challenge focuses on the AMA's role in accreditation. The FTC asserts that the AMA's representation of the commercial and economic interests of physicians is a conflict of interest with its LCME membership. This and other FTC arguments are based on their belief that the accreditation process can be used to limit the number of physicians, and therefore, serve physicians' economic interests. However, the FTC offers no evidence of such abuse of the accreditation process, arguing that the AMA's mere involvement should disqualify the LCME from recognition.

FTC investigators have sifted through AMA files for several months, reportedly copying over 6,000 pages of documents in the accreditation area alone. AAMC also has met with FTC investigators to establish strict procedures for their review of our Liaison Committee files, but to date no materials have been requested.

The AAMC staff and legal counsel will be working closely with the AMA general counsel to defend the legitimacy of the LCME. Both AAMC and AMA are deeply concerned that the entire private sector system of accrediting higher education institutions may crumble if the involvement of the concerned profession can be so easily challenged. The Office of Education has postponed consideration of this question until March.

B. Health Manpower Legislation

H.R. 5546, the Health Professions Educational Assistance Act of 1976, was signed into law on October 12, 1976. Provisions of this legislation were summarized in the Fall 1976 CAS BRIEF. Dr. Cooper described the AAMC's unsuccessful attempts to have removed from the legislation the provision concerning U.S. citizens studying medicine abroad which in effect encroaches on right of faculties to select students. AAMC was able, however, to have removed from the legislation the actual assignment by the Secretary of specific individuals to specific schools. After three years of debate through two sessions of Congress, the final bill, with the exception of the U.S. foreign medical student provision, is reasonable and provides for federal support for medical education in a satisfactory manner.

C. Other Legislation

Next year will be a banner year in Congress for biomedical research legislation. The Cancer Act, the Cardiovascular, Lung, and Blood authority, the Research Training Act, and HEW Appropriations must be renewed in 1977. Other legislation of interest to the CAS will be the Clinical Laboratories bill. One other bill that was introduced at the end of the session by the Chairman of the Subcommittee of Labor and Management in the House was to direct the NLRB to designate Housestaff as employees and not students. Finally, the Talmadge Amendment vis-a-vis Social Security Act, Medicare, and Medicaid which was introduced will probably be reintroduced in its previous or in a modified form in the next session. It will have implications for the reimbursement of physicians and hospital costs for the institutions. AAMC will be deeply involved, working in concert with the constituents, as these several matters are developed.

D. New MCAT

Dr. Cooper spoke briefly about the New MCAT which will be first administered in the spring of 1977. The test incorporates the latest testing methodologies and will reflect the advances in medical science, changing needs for doctors, and widely differing medical school curricula. It will provide an enlarged basis of information to assist admission committees in selecting students who are preparing to enter the medical profession. AAMC has prepared a 48-page manual, The New MCAT Student Manual, as a comprehensive guide to students who will be planning to take the New MCAT.*

*For more on New MCAT see Minutes page 7

V. Action Items

A. New Membership Applications

In accordance with the established procedures election to membership in AAMC of Academic Society Members is upon recommendation by the Council of Academic Societies to the Executive Council and by majority vote in the Assembly. It was the recommendation of the CAS Administrative Board that the following applications for membership be approved by the full Council:

American Society for Clinical Nutrition
American Society of Clinical Pathologists

ACTION: The above applications for membership were unanimously approved.

NOTE: On November 13, 1976 by action of the AAMC Assembly, these societies were elected to AAMC Membership, increasing to 61 the number of organizations in the CAS.

B. Election of Members to the 1976-77 CAS Administrative Board

ACTION: The Council elected by ballot the following to serve on the CAS Administrative Board to take office at the conclusion of the CAS Business Meeting:

CHAIRMAN-ELECT
Robert M. Berne, M.D., Representative, American Physiological Society (Chairman, Department of Physiology, University of Virginia School of Medicine)

For Administrative Board, from the Basic Sciences (to complete the unexpired term of Dr. Berne on the Administrative Board)

one-year term
Roy C. Swan, M.D., Representative, Association of Anatomy Chairmen (Chairman, Department of Anatomy, Cornell University Medical Center)

For Administrative Board, from the Clinical Sciences

Eugene Braunwald, M.D., Representative, Association of Professors of Medicine (Chairman, Department of Medicine, Harvard University Medical School

G.W.N. Eggers, Jr., M.D., Representative, Association of University Anesthetists (Chairman, Department of Anesthesiology, University of Missouri)

Samuel Thier, M.D., Representative, American Federation for Clinical Research (Chairman, Department of Internal Medicine, Yale University)

The roster of the CAS Administrative Board for 1976-1977 is included in the 1977 CAS Directory.

C. Election of 1976-77 Nominating Committee

ACTION: In Accordance with the CAS Rules and Regulations (Section V. Paragraph 1), the Nominating Committee is comprised of seven members of the Council. The Chairman of the Administrative Board serves as the nonvoting Chairman of the Nominating Committee. The Committee consists of six individuals (three basic science and three clinical science) who are chosen from among the representatives present at the Annual Fall Meeting of the Council by a majority vote. It was determined during the year just past that the CAS Administrative Board would be ineligible for nomination to these six seats.

Nominations were made from the floor, and a written ballot was conducted. The following were chosen to comprise the Nominating Committee, which will be chaired by Dr. Jay Bollet:

From the Basic Sciences

Carmine D. Clemente, Ph.D., Director, Brain Research Institute, UCLA School of Medicine

Ronald W. Estabrook, Ph.D., Dean, Graduate School of Biomedical Sciences, University of Texas Southwestern Medical School

Frank E. Young, M.D., Ph.D., Chairman, Department of Microbiology, University of Rochester School of Medicine & Dentistry

From the Clinical Sciences

Nicholas Greene, M.D., Department of Anesthesiology, Yale University School of Medicine

Warren Stamp, M.D., Chairman, Department of Orthopedics, University of Virginia School of Medicine

Allan B. Weingold, M.D., Chairman, Department of Ob-Gyn, George Washington University School of Medicine

VI. Discussion Items

A. Designation of Public Affairs Representatives to CAS

Dr. Morgan described the development of the AAMC/CAS program designed to promote closer interaction between the CAS member societies and the AAMC. Member societies have been asked to designate a public affairs representative who will be assigned the responsibility to work closely with the AAMC staff for a period of four to six years. A special workshop will be held on December 12-14 to acquaint these representatives with the details of the legislative process.

B. Public Policy

The Council discussed the implications of current federal efforts to regulate clinical laboratories. The possibility that regulatory efforts will impair the ability of research clinical laboratories to initiate the provision of new laboratory tests in the clinical setting was of particular focus. The Council also discussed the implications of new legislative recognition of categorical diseases. This was particularly stimulated by the recent establishment of the National Arthritis Advisory Board, the National Diabetes Advisory Board, and a National Commission on Digestive Diseases. There was a division of opinion on whether or not this trend threatens the integrity of the national research effort.

A position paper on Clinical Research Training was presented for comment and criticism. This paper focuses on the problem of tracking the development of holders of the M.D. degree who are interested in clinical research. There is a growing body of evidence that suggests the needed manpower for clinical research may be in short supply in the future.

C. Coordinating Council on Medical Education and Its Subcommittees

The activities of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education were reported. There was a discussion of the problems related to the veto power residing in each member of the Coordinating Council on Medical Education and the issue of whether the CCME and the liaison committees should have an independent staff.

VII. Information Items

A. CAS Representation in the Group on Medical Education (GME)

Dr. Swanson reviewed the information presented in the agenda on the GME and the Executive Council recommendation that the CAS and the COTH be provided the opportunity to designate individuals for membership in the GME. In the near future, information regarding the designation of GME representatives will be sent to society officers.

B. New MCAT

The New MCAT Student Manual, designed to describe in detail to students the characteristics of the new test and to provide them with a practice test, has been published by AAMC. The New MCAT was developed at a cost of $1 million by the American Institutes for Research in the Behavioral Sciences of Palo Alto, California, which spent 2 years developing specifications in consultation with medical schools, premed faculties, doctors, and students; and 3 years developing the actual test.

The New MCAT will take six hours to complete -- twice as long as the old one. The number of items has been increased from 221 to 363. The New MCAT reflects recent refinements in testing procedures and although it does not require more knowledge on the part of the student, it will test a much greater array of skills relating to ability to assimilate knowledge, to perceive relevance, consistency, accuracy, and objectivity and to recognize relationships and trends.

The science section of the old MCAT has been broken into two parts -- science knowledge, and science problems. The latter is more a test of ability than knowledge and contains new kinds of questions. The verbal portion of the test has been expanded from 20 to 90 minutes. The "Quantitative" section of the old MCAT required the ability to solve simple mathematical, algebra, and geometry problems, and read charts and graphs. The new quantitative section puts these concepts in contexts that require additional analytical skills in an attempt to test the ability of medical school applicants to analyze and diagnose a medical problem. A chart, for example, must not only be understood, but conclusions must be extrapolated from it.

Dr. Swanson emphasized that the test is not designed to weed out those unsuitable for medical education but to give admissions officers a finer tool for evaluating a student in light of his or her experience and professional goals.

The new test leaves out the old MCAT's section on "general knowledge." This section was found to have a very low priority among the other factors influencing selection; also, medical students are coming from such diverse cultural backgrounds that it is impossible to devise a standard measure for general knowledge.

The new MCAT is now being evaluated at 20 medical schools, and continuing evaluation studies will be directed at identifying as precisely as possible the constraints that should be placed on the use of the scores reported.

C. CAS Communications

Dr. Swanson invited criticism from the members of the CAS Brief, which has been published in its new format for one year, and of the document summarizing AAMC programs that appears annually in the CAS Directory. Any ideas that members have to improve communications between AAMC, CAS, and the member societies will be most welcome.

D. Annual Program

The afternoon program of the Council is entitled, "The Role of Medical Education in Reducing Medical Costs and the Demand for Medical Services." Duncan Neuhauser, Assistant Professor of Health Services Administration of Harvard University School of Public Health, is to take the affirmative position that medical education must especially focus on reducing medical costs and demand for medical services and Sherman Mellinkoff, Dean of the University of California, Los Angeles, School of Medicine will take the position that the primary purpose of medical education is to teach physicians to provide each individual patient the best possible services, and costs should be only a secondary consideration. The question of whether a physician acting as the fiduciary agent for a patient can also assume a larger societal responsibility to control overall costs will be debated.

VIII. Adjournment

ACTION: The meeting was adjourned at 12:30 p.m.

Attachments (2)

MHL:eah

Report of the Chairman
Council of Academic Societies*

INTRODUCTION

The year since the last Annual Meeting of the Council of Academic Societies, has seen many developments of importance to biomedical academicians. The Council of Academic Societies, as one of the three Councils of the AAMC, has played a significant role in these developments. I will recount some of the major events, attempt to delineate where ongoing effort is needed, and project the challenges the next twelve months will bring. The overriding need at present is for a forward look and planning for the future. We must be ready for what the future brings; indeed we must be influencing the direction of the future.

First, let me emphasize that the rate of change in national policies which affect our programs and our institutions is not slackening. There are deep-seated national and local concerns regarding the provision of safe, effective, and affordable medical services to this nation's citizens. These concerns are being translated into new concepts about policy-making and about where the authority to determine how policy should be implemented should lie. The old traditions are not only being challenged--they are falling. It is up to us to find or build our new places in the biomedical educational community.

Most of us embarked on our professional careers in an era when academic medical centers were expected only to educate physicians to the point of granting the M.D. degree and conduct research into the nature of biological processes and disease. The provision of medical services necessary to accomplish these primary missions was expected, but the academic institutions and their faculties were not considered to be a significant medical service resource and were certainly not considered to have a significant stake or a concern about policies which impacted upon medical service delivery.

Last year, the 400 member hospitals of the Council of Teaching Hospitals, that is the medical school-associated hospitals, provided 26% of the short-term hospital services in the United States and served patients through 41,000,000 out-patient visits. In addition to these enormous medical services, the 400 hospitals in the Council of Teaching Hospitals and the other medical school-affiliated hospitals served as the educational institutions for 93% of the graduate medical students on duty last year, that is the residents and fellows. Thus, the institutions for which we academicians have some degree of responsibility provided nearly all of the graduate medical education and a highly significant proportion of the medical services in this country.

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*Presented by Rolla B. Hill, Jr., M.D., Council of Academic Societies Annual Business Meeting, November 12, 1976, San Francisco, California

We must now recognize, then, that academic medicine's role in the United States has grown beyond the narrow mission of undergraduate medical education and research. Our academic medical centers are major providers of medical services, and graduate medical education is nearly totally within our sphere of responsibility. Policy changes in all areas related to the health care system are of importance to our institutions and to us as faculty. Furthermore, as citizens we must assume a role beyond the narrow protection of our own self-interest. Medical care and health-sustaining services are going to be increasingly scrutinized. Not only are we, as academicians, going to be subjects of that scrutiny; we are also going to be asked to provide ideas for the solution of issues which come to light. At the same time as we add on layers of complexity, however, we must not lose sight of the fact that scholarly academic pursuits and achievements are at the heart of our mission.

Time does not permit a complete recounting of all the issues considered by the CAS and its Administrative Board during the past year. I will briefly mention the major ones. Several are in your agenda for information or further discussion. All have been reported at length through the AAMC "Weekly Activities Report" or in memos to CAS representatives and officers.

MAJOR ISSUES

The Health Manpower bill, passed in the closing hours of the 94th Congress, represents a major change in the direction of physician manpower policy. We may not all like every provision in it. I can tell you unequivocally, though, that it is more useful by orders of magnitude than the bill we once thought was forthcoming, and the AAMC had much to do with the improvement.

Clearly, the impetus to continue to enlarge the number of physicians graduating from U.S. medical schools is gone. This bill is directed toward modifying the distribution of physicians. That the Congress recognizes that academic medical centers have prime responsibility for graduate medical education is demonstrated by the requirement in the Act that a proportion of first-year graduate medical education positions in hospitals, both directly owned by or affiliated with academic medical centers, must be in primary care specialties in order for the medical school to qualify for capitation. Considering the capitation requirements related to graduate medical education which were contemplated in early versions of the Manpower bill, this requirement is reasonable and can be met by the schools and their affiliated hospitals if the necessary resources for the development of high-quality, primary care specialty training is forthcoming.

A capitation requirement which was introduced without prior discussion in the last stages of the House-Senate Conference has caused considerable debate. Schools accepting capitation will have to agree to set aside a number of positions (the number to be determined by the Secretary) for U.S. citizens who have successfully completed two years of study in a foreign medical school and have passed Part I of the National Board. The language of the bill forestalls the schools from applying any academic standards except passing the Part I exam. This is an invasion of the traditional right of institutions of higher learning to set their own admissions standards. Because the provision was enacted into law without prior discussion or public debate, the Association is exploring how this invasion can be modified.

IOM Report.--The report on Medicare-Medicaid Reimbursement Policies by the Institute of Medicine was issued in March. The AAMC responded to the recommendations of that report and has testified to the Congress on its reimbursement recommendations. Hopefully, policies will emerge which will resolve the issues surrounding reimbursement in the teaching setting, which have been with us since the passage of the Medicare legislation over ten years ago.

N.L.R.B. Decision.--The decision by the National Labor Relations Board to decline jurisdiction over labor negotiations between hospitals and housestaff organizations on the basis that house officers are students and not employees has placed the responsibility on us to make graduate medical education a well-conceived learning experience. The question of whether house officers are employees or students or both can only be finally resolved if those of us responsible for graduate medical education insist that the subversion of educational programs to provide medical services must be terminated.

C.C.M.E.--The Coordinating Council on Medical Education issued a report on the status of foreign medical graduates in the United States. This report had the full endorsement of the AAMC and was based largely on recommendations developed by a task force of the AAMC in 1974. The report is directed toward providing high-quality clinical education to foreign exchange students, while curtailing the exploitation of FMGs by hospitals under the guise of education, and limiting the opportunities for FMGs to assume permanent careers as physicians in the United States. Many of these recommendations are being implemented by the State Department through existing authorities, and authorities provided in the new Manpower bill will further permit the adoption of the foreign medical graduate report recommendations.

President's Biomedical Research Panel.--The President's Biomedical Research Panel issued its report this year. The CAS and the COD both had the opportunity to meet with the Panel early in its deliberations and the AAMC collaborated with the American Council on Education and the Rand Corporation in developing studies of the contribution of our institutions to the research endeavor of the Federal Government. The report, with its insistence on the need for stability in research funding, some of the studies, and the Association's response to the report have been sent to you. A major issue raised in our response is the degree to which the National Institutes of Health should be held responsible for the conduct of clinical trials and for the transfer of research-proven ideas to patient care, as opposed to fundamental biomedical research.

Freedom of Information & N.I.H.--During the year the question whether the Freedom of Information statutes prevented the peer-review study sections of the NIH from conducting their business in a fashion which would protect from infringement the ideas of biomedical investigators has still not been resolved in a fashion which will permit the continuation of the study section system as we have known it. However, much progress has been made and we hope that the next session of Congress will resolve the question positively.

ONGOING ISSUES

These represent only major events. Many more issues were dealt with; most remain the subject of ongoing concern. Principal among these were the following:

Accreditation.--The CAS and the AAMC have become increasingly involved in the accreditation of not only undergraduate medical education, but graduate and continuing medical education as well. The need to provide assurances to both students and the public that our institutional programs are of the highest quality is rising as the demand for accountability grows. Ultimately, the judgment of whether educational institutions are conducting programs which meet acceptable standards of quality require the judgment of faculties operating through a process which eliminates conflict-of-interest. The CAS has a major role to play in this process. The establishment of the Coordinating Council on Medical Education (CCME) and its subsidiary liaison committees was a step toward the development of that process, and CAS members do yeoman work on the committees and the site visit teams. It must be questioned, however, whether significant strides can be made toward further improvement of both the process for accreditation and the quality of programs when the staffing of these bodies is provided by the organization which has held sway over the accreditation system even though its responsibility for medical education has steadily declined.

Physician Distribution.--Physician Distribution will remain an ongoing issue. Even though we achieve the required 50% of first-year graduate medical education positions in the primary care specialties by 1980, how the remaining 50% of medical school graduates should be distributed amongst the remaining specialties and subspecialties will be a subject of major concern. The CAS and the AAMC must be prepared to work with other organizations and agencies to make the best prediction possible for specialty needs. We must also responsibly point out where policies, beyond those relating to education, conflict with the projected needs for medical services. Even though changing the present, procedure-dominated reimbursement system may cause painful readjustments within our own institutions, we should assess whether current reimbursement policies are in the public interest and provide for safe, effective, and affordable medical care.

Research Training.--Research training, especially clinical research training, suffers from neglect as the high public concern for accessibility to medical services has preempted the attention of policy-makers and created almost single-minded devotion to the concept of primary care. Simultaneously, the growing movement toward minute regulation of research involving human subjects may make the prospect of developing a career as a competent, clinical investigator less and less attractive to research-oriented young men and women. Whether there is a serious downward trend in the development of young clinical investigators is not yet clearly demonstrated, but that possibility must be of major concern to the Council of Academic Societies.

During the next year, the Congress intends to focus particular attention on the question of whether the fruits of biomedical research are being transferred to the provision of health services safely and expeditiously. The issues around this debate will include whether there are or will be sufficient skilled, research-trained clinicians who can accomplish this task in the future. An objective assessment of the research training in all the biomedical disciplines (both basic and clinical) is needed. The member societies of CAS and the AAMC must decide what role they should play in that assessment.

Related to this is the question of whether the continued trend toward seeking categorical recognition by the Congress of one particular disease or another is in the public interest. This year saw special legislative recognition provided to diabetes, arthritis, and gastroenterology. Next year could see several more diseases singled out to have special advisory committees or other signal federal attention. Gratifying as it may be to those who have a special interest in a disease to have that interest recognized in law, we as responsible scientists must question whether appealing to uncritical legislators in order to achieve possible short-term advantages is scientifically justified and, in the long-term, sound public policy.

Minority Constituents.--The Council of Academic Societies, indeed the entire AAMC, needs to examine ways in which we can respond to the needs of its minority constituents. In this era of enormous diversity, when there are hardly two medical schools with the same goals and missions, the same tables or organizations, the same curricula, a majority opinion, or the needs of a large group must not be allowed to sway policy to the detriment of smaller groups. Similarly, the needs of small groups must not be ignored because they are not shared by larger groups. The biomedical, educational, and service missions in which we all share cannot function properly unless all of its components function well.

CONCLUSION

These are but a few of the problems and issues which are facing us and will face us in the future. The CAS member societies, along with the AAMC, will play an increasing role in the debates surrounding these and in resolving them responsibly and in the public interest.

The officers and Administrative Board of the CAS, recognizing that the intensity of our engagement with public policy development will increase, have moved towards establishing mechanisms to provide closer interaction between the society representatives, the Administrative Board, and the AAMC staff. A discussion of the details of how this may be accomplished will occupy a significant portion of this morning's meeting.

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 for Clinical Pharmacology and Therapeutics

MAILING ADDRESS: 1718 Gallagher Road, Norristown, Pennsylvania 19401

PURPOSE: See "Objectives" or page 16 of the Society Directory

MEMBERSHIP CRITERIA: See "Qualification ..." or top of page 17 of the Society Directory

NUMBER OF MEMBERS: Voting 846, Total 1,023

NUMBER OF FACULTY MEMBERS: Not available

DATE ORGANIZED: May 1, 1900

OBJECTIVES

The objectives of the Society shall be to promote and advance the science of human pharmacology and therapeutics, and in so doing to maintain the highest standards of research, education, and exchange of scientific information. In its efforts to meet the primary objectives, the Society shall:

A. Stimulate teaching of human pharmacology and therapeutics as a scientific discipline in medical schools and various other academic institutions, as well as participate in educational efforts directed toward the continuing education of practicing physicians.

B. Provide consultation and advice for the better evaluation of the biochemistry, clinical pharmacology, safety, and therapeutic efficacy of drugs and other therapeutic measures.

C. Act as an advisory body to educational institutions, governmental agencies, and such other organizations and bodies as seem indicated and as determined by the Board of Directors of the Society.

D. Provide for additional educational and scientific activities as are deemed necessary by the Society.

QUALIFICATION FOR MEMBERSHIP

I. MEMBER

(a) shall have earned the degree of Doctor of Medicine or a doctor's degree in any one of the biomedical sciences, or show evidence of its equivalent in experience and performance.

(b) must demonstrate to the Membership Committee his sincere interest in clinical pharmacology and therapeutics . . . and show evidence of achievement through meritorious contributions to the literature.

II. CANDIDATE MEMBER

Non-voting and designed for individuals exhibiting interest in human pharmacology, primarily those in training but who have not yet fulfilled the qualifications for voting membership. This classification will be limited to a period of five years.

Candidate members will be considered by the Membership Committee for advancement to full Membership upon new application to the committee demonstrating additional qualifications.

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

June 20, 1970 1. Constitution & Bylaws

March 18 & 19, 1976 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 and 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.

Elmer H. Funk, M.D.

Elmer H. Funk, Jr., M.D.
(Completed by - please sign)

January 10, 1977
(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 Surgery of the Alimentary Tract, Inc.

MAILING ADDRESS:
Larry C. Carey, M.D., Secretary
410 West 10th Avenue
Columbus, OH 43210

PURPOSE:

The objectives of the Society shall be to stimulate, foster and provide surgical leadership in the art and science of patient care, teach and research the diseases and functions of the alimentary tract, provide a forum for the presentation of such knowledge, and encourage training opportunities, funding, and scientific publications supporting the foregoing activities.

MEMBERSHIP CRITERIA:
To qualify for membership, a candidate must have (1) a degree from a medical school acceptable to the Trustees, (2) a license to practice medicine in his state, province, or country and (3) a demonstrable interest in diseaaes of the alimentary tract. In addition, the candidates customarily have (1) evidence of original research and published reports, (2) Fellowship in the American College of Surgeons, and (3) certificati on by an appropriate board.

NUMBER OF MEMBERS:

NUMBER OF FACULTY MEMBERS:
Not applicable

DATE ORGANIZED:
1960

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

Included in front portion of Membership Directory enclosed — 1. Constitution & Bylaws

See Enclosure — 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

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X YES _____ NO

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

_____

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

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___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.

Current records do not have copy of letter. Identification number is 36-6147052, granted August 9, 1966

Miriam E. Rollings
(Completed by - please sign)

1-7-77
(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: Society of Teachers of Emergency Medicine

MAILING ADDRESS: 3900 Capital City Boulevard, Lansing, Michigan 48906

PURPOSE: The Society of Teachers of Emergency Medicine (hereafter called "the Society") is organized and operated exclusively for educational purposes, and in particular, to pursue the following objectives:

(a) Educating teachers of emergency medicine and encouraging its development as an academic discipline;

(b) Applying sound educational principles for the improvement of the quality of teaching in the field of emergency medicine;

(c) Promoting research in educational methods and clinical procedures which will improve the teaching of emergency medicine in universities and hospitals;

(d) Providing a forum for the interchange of experience and ideas among educators and other interested persons.

This organization is not organized for profit, and no part of any net earnings hereof shall inure to the benefit of any member, director, officer, or private individual (except that reasonable compensation may be paid for services rendered to or for the organization).

MEMBERSHIP CRITERIA:

Section 1. Members

Membership shall consist of those individuals who contribute, both monetarily and/or professionally to the Society as defined by the above purposes and objectives.

The Society shall be comprised of four classification of members:

(a) Active Members. Any physician who is actively involved in teaching physicians or medical students emergency medicine shall be eligible for active membership.

(b) Associate Members. Any non-physician actively involved in the teaching or organization of teaching physicians emergency medicine shall be eligible for associate membership. Such members would need sponsorship by an active member with the same benefits.

(CONTINUED NEXT PAGE)

(c) Honorary Members. An honorary membership may be conferred by the Executive Committee upon any non-member or member who has made an exceptional contribution to education in emergency medicine.

(d) Emeritus Members. Any Active Member who attains retirement age and requests a change in the status of his membership may be granted an emeritus membership, subject to such standards and requirements as may from time to time be established by the Bylaws.

Each application for membership shall be subject to initial approval by the Membership Committee.

Associate, Honorary, and Emeritus Members shall have the privilege of the floor at all meetings, the right to vote, and the right to hold elective office.

NUMBER OF MEMBERS: 75

NUMBER OF FACULTY MEMBERS: 60 (approximately)

DATE ORGANIZED: May 23, 1975 - organizational meeting
January 13, 1976 - articles of incorporation filed

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

May 14, 1976 1. Constitution & Bylaws

Program May 19, 1977
Minutes May 14, 1976 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?

___a. Approved by IRS

___b. Denied by IRS

_X_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.

Charles B. Maclean Ph.D.
(Completed by - please sign)

April 5, 1977
(Date)

aamc association of american medical colleges

B A L L O T

COUNCIL OF ACADEMIC SOCIETIES

1977-78

ADMINISTRATIVE BOARD POSITIONS

CHAIRMAN-ELECT

Vote For One:

FREEDMAN, Daniel X., M.D.

American Association of Chairmen of Departments of Psychiatry

FREEDMAN, DANIEL X, b. Lafayette, Ind, Aug. 17, 21; m. 45. PSYCHIATRY. B.A, Harvard, 47; M.D, Yale, 51. Intern pediat, sch. med. Yale, 52-55, res. psychiat, 55, instr, 55-58, chief res, 55-56, asst. prof, 58-61, assoc. prof, 61-64, prof, 64-66, dir. psychopharmacol. unit, 58-66; PROF. PSYCHIAT. & CHMN. DEPT, UNIV. CHICAGO, 66- Attend. psychiatrist, Vet. Admin. Hosp, West Haven, Conn, 55-66; assoc. psychiatrist, Grace-New Haven Community Hosp, 55-66; consult, juvenile courts, 55-57; Fairfield State Hosp, 58-66, U.S. Dept. Army, 65-67; career investr, Nat. Inst. Ment. Health, 57-66, consult. psychopharmacol. study sect, 60-65, mem. drug eval. comt, 65-67, res. scientist, develop. review comt, 70-; mem. comt. on brain sci, Nat. Res. Coun, 70-; chief ed, Archives Gen. Psychiat. U.S.A, 42-46. Am. Psychiat. Asn; Am. Soc. Pharmacol. & Exp. Therapeut; Am. Col. Neuropsychopharmacol; Soc. Psychophysiol. Res; Am. Med. Asn; Group Advan. Psychiat; Int. Brain Res. Orgn; Int. Col. Neuropsychopharmacol. Psychopharmacology; psychoanalytic, neurophysiologic and social investigation in schizophrenia; central nervous system determinants of allergy; drugs, brain function and behavior; methodology of drug studies. Address: Dept. of Psychiatry, University of Chicago, 950 E. 59th St, Chicago, IL 60637.

(CAS Administrative Board, 1975-78)

OLIVER, Thomas K., Jr., M.D.

Association of Medical School Pediatric Department Chairmen

OLIVER, THOMAS K, JR, b. Hobart Mills, Calif, Dec. 21, 25; m. 49; c. 2. PEDIATRICS. California, Berkeley, 43-45; M.D, Harvard Med. Sch, 49. Instr. pediat, med. col, Cornell, 53-55; asst. prof, Ohio State, 55-60, assoc. prof, 60-63; PEDIAT, Univ. Wash, 63-65, prof, 65-70; PROF. & CHMN. DEPT, SCH. MED. UNIV. PITTSBURGH, 70-; MED. DIR, CHILDREN'S HOSP. PITTSBURGH, 70- Spec. fel. neonatal physiol, Karolinska Inst, Sweden, 60-61. Med.C, 51-53, 1st Lt. Soc. Pediat. Res; Am. Pediat. Soc; Am. Acad. Pediat. Neonatal biology; pulmonary physiology in childhood; acid-base physiology. Address: Dept. of Pediatrics, Children's Hospital of Pittsburgh, 125 DeSoto St, Pittsburgh, PA 15213.

(CAS Administrative Board, 1974-77)

ADMINISTRATIVE BOARD, CLINICAL SCIENCES

Vote For One: (To be elected for a term of two years to complete the unexpired term of Dr. Eugene Braunwald)

BRASEL, Jo Anne, M.D.
Endocrine Society

BRASEL Jo Anne Cert Pd 65. b 34 Salem Ill. MD Colo 59. Intern Pd 59-60 Res Pd 60-62 (NY Hosp-Cornell Med Center) Fell Pd Endocrin (Johns Hop) 62-65. Asst Prof Pd (Johns Hop) 65-68 Asst Prof Pd 69-71 Assoc Prof Pd 71-72 (both at Cornell) Assoc Prof Pd & Chief Div Growth & Devel Inst Human Nutrition (Colum P&S) 72—. AFCR-EndocrinS-Soc Developmental Biology-Am Soc Clin Nutrition-Am Inst Nutrition-SPR-Alpha Omega Alpha. Colum P&S Black Bldg 217 630 W 168th St New York NY 10032 Tel (212) 579-3984

WILSON, Frank C., Jr., M.D.
American Academy of Orthopaedic Surgeons

WILSON, FRANK C(RANE), b. Rome, Ga, Dec. 29, 29; m. 51; c. 3. MEDICINE, ORTHOPEDIC SURGERY. A.B, Vanderbilt, 50; M.D, Med. Col. Ga, 54. Instr. ORTHOP. SURG, Columbia, 63; SCH. MED, UNIV. N.C, CHAPEL HILL, 64-65, asst. prof, 65-68, assoc. prof, 68-71, PROF, 71- Markle scholar, 66- Chief div. orthop. surg, N.C. Mem. Hosp, 67. Consult, Watts Hosp, Durham, N.C, 65- Dipl, Am. Bd. Orthop. Surg, 67. U.S.N, 56-58, Lt. Comdr. AAAS; Am. Col. Surg; Am. Rheumatism Asn. Trauma; infections of bones and joints; rheumatoid arthritis. Address: Division of Orthopedic Surgery, North Carolina Memorial Hospital, Chapel Hill, NC 27514.

ADMINISTRATIVE BOARD, BASIC SCIENCES

Vote For Four: (One to be elected for a term of one year to complete the unexpired term of Dr. Leslie Webster)

BROWN, David M., M.D.

Academy of Clinical Laboratory Physicians and Scientists

BROWN David M Cert Pd 66 (PdNeph) 74. U Minn Ho. Minneapolis MN 55455 Tel (612) 373-8114

DEVLIN, Thomas M., Ph.D.

Association of Medical School Departments of Biochemistry

DEVLIN, THOMAS M(cKEOWN), b. Philadelphia, Pa, June 29, 29; m. 53; c. BIOCHEMISTRY. B.A, Pennsylvania, 53; Nat. Sci. Found. fel, Hopkins, 54-55, U.S. Pub. Health Serv. fel, 55-57, Ph.D.(physiol. chem), 57. Asst. org. chem, Sharples Corp, Pa, 47-49; asst. biophysics, Johnson Found, Pennsylvania, 49-53; res. assoc. enzyme chem, Merck Inst, 57-61, sect. head, biol. cancer res, 61-66, dir. enzymol, 66-67; PROF. & CHMN. DEPT. BIOL. CHEM, HAHNEMANN MED. COL. & HOSP, 67- Vis. res. scientist, Brussels, 64-65. AAAS; Am. Soc. Biol. Chemists; Am. Asn. Cancer Res; Biochem. Soc; Am. Soc. Cell Biol; Am. Chem. Soc; N.Y. Acad. Sci. Enzyme chemistry; oxidative phosphorylation and electron transport; mitochondrial physiology and biogenesis; biochemical control mechanisms; intermediary metabolism of malignant tissues; cancer chemotherapy; spectrophotometric techniques. Address: Dept. of Biological Chemistry, Hahnemann Medical College, 235 N. 15th St, Philadelphia, PA 19102.

JONES, Mary Ellen, Ph.D.

American Society of Biological Chemists

JONES, MARY ELLEN, b. La Grange, Ill, Dec. 25, 22; c. 2. BIOCHEMISTRY. B.S, Chicago, 44; U.S. Pub. Health Serv. fel, Yale, 50-51, Ph.D, 5. Res. chemist, Armour & Co, 42-48; Atomic Energy Cmn. fel, biochem. res. lab, Mass. Gen. Hosp, 51-53, Am. Cancer Soc. fel, 53-55, assoc. biochemist, 55-57; asst. prof. biochem, Brandeis Univ, 57-60, assoc. prof, 60-66; Univ. N.C, Chapel Hill, 66-68, prof, 68-71, partic. assoc. prof. zool, 67-69, PROF, 69-71; BIOCHEM, UNIV. SOUTH. CALIF, 71- Am. Cancer Soc. scholar, 57-62, dir. dent. training grant, 62-66; mem. biochem. study sect, Nat. Insts. Health, 71- AAAS; Am. Chem. Soc; Am. Soc. Biol. Chem; N.Y. Acad. Sci; Am. Cancer Soc. Enzymology, biosynthetic and transfer reactions, metabolic regulation of enzymes; carbamyl phosphate, acetyl-coenzyme A, cathespsin C and transamidation reactions. Address: Dept. of Biochemistry, University of Southern California School of Medicine, 2025 Zonal Ave, Los Angeles, CA 90033.

LIEBERMAN, Seymour, Ph.D.

Endocrine Society

LIEBERMAN, SEYMOUR, b. N.Y.C, Dec. 1, 16; m. 44; c. 1. BIOCHEMISTRY. A.B, Brooklyn Col, 36; M.S, Illinois, 37; Ph.D.(chem), Stanford, 41. Chemist, Schering Corp, 38-39; Rockefeller Found. asst, Stanford, 39-41; spec. res. assoc, Harvard, 41-45; assoc, Sloan-Kettering Inst, 45-50; asst. prof. BIOCHEM, COL. PHYSICIANS & SURG, COLUMBIA UNIV, 50-52, assoc. prof, 52-62, PROF, 62- Traveling fel. from Mem. Hosp, New York to Basel, Switz, 46-47; mem. panel steroids, comt. on growth, Nat. Res. Coun, 46-50, panel endocrinol, 55-56; endocrinol. study sect, Nat. Insts. Health, 58-63, mem, Insts, 59-65, chmn, 63-65, gen. clin. res. ctrs. comn, 67-70; med. adv. comt, Pop. Coun, 61-; assoc. ed, J. Clin. Endocrinol. & Metab, 63-67. AAAS; Am. Chem. Soc; Am. Soc. Biol. Chem; Endocrine Soc.(Ciba Award, 52, v.pres, 67, Koch Award, 70). Steroid chemistry and biochemistry; metabolism of hormones; steroid hormone-protein conjugates. Address: College of Physicians & Surgeons, Columbia University, 630 W. 168th St, New York, NY 10032.

Continued ....

ADMINISTRATIVE BOARD, BASIC SCIENCES (Continued)

MANDEL, H. George, Ph.D.

Association for Medical School Pharmacology

MANDEL, H(AROLD) GEORGE, b. Berlin, Ger, June 6, 24; nat; m. 53; c. 2. PHARMACOLOGY. B.S, Yale, 44, Ph.D.(org. chem), 49. Asst. & lab. instr. chem, Yale, 42-44, lab. instr. org. chem, 47-49; res. assoc. PHARMACOL, SCH. MED, GEORGE WASH. UNIV, 49-50, asst. res. prof, 50-52, assoc. prof, 52-58, PROF, 58-, CHMN. DEPT, 60- Adv. Commonwealth Fund fel, Molteno Inst, Eng, 56; Pasteur Inst, France, 57; lectr, U.S. Naval Dent. Sch, 59-61, 71-; Washington Hosp. Ctr, 60-66; Commonwealth Fund sabbatical leave, Univ. Auckland, N.Z. & Univ. Med. Sci, Thailand, 64. Consult, Fed. Aviation Agency, 61-62. Mem. biochem. comt, Cancer Chemother. Nat. Serv. Ctr, 58-61; med. adv. comt, Therapeut. Res. Found, Inc, 62-; pharmacol. & exp. therapeut. B study sect, U.S. Pub. Health Serv, 63-68; comt. probs. drug safety, Nat. Acad. Sci-Nat. Res. Coun, 65-71, mem. drug metab. workshop progs, N.Y. Univ, 66, George Wash. Univ, 67 & Univ. Calif, 68; mem. cancer chemother. comt, Int. Union Against Cancer, 66, Am. Cancer Soc. Eleanor Roosevelt Int. Fel, Chester Beatty Res. Inst, London, 70-71; mem. cancer res. training comt, Nat. Cancer Inst, 70; res. comt, Children's Hosp, Wash. D.C, 69-; sci. adv. comt, Registry Tissue Reactions to Drugs, 70- Int. Pharmacol. Cong. travel award, Prague, 63. U.S.A, 44-46. AAAS; Am. Soc. Pharmacol. & Exp. Therapeut.(Abel award, 58, secy, 61-63, pres. elect, 72-73); Am. Chem. Soc; Am. Soc. Biol. Chem; Am. Asn. Cancer Res; Asn. Am. Med. Cols; Am. Soc. Microbiol. Drug metabolism; mechanism of drug action; biochemistry of nucleic acids of normal and malignant tissue; antimetabolites and other anti-cancer drugs; action of drugs on microorganisms. Address: Dept. of Pharmacology, George Washington University School of Medicine, Washington, DC 20005.

PRESTON, James B., M.D.

Association of Chairmen of Departments of Physiology

PRESTON, JAMES B(ENSON), b. Nelsonville, Ohio, Feb. 4, 26; m. 47; c. 3. PHYSIOLOGY. Ohio Wesleyan, 44-45, 47-48; M.D, Cincinnati, 52. Intern, Res. & Ed. Hosps. & instr. pharmacol, col. med, Illinois, 52-54; instr. PHYSIOL, STATE UNIV. N.Y. UPSTATE MED. CTR, 54-56, asst. prof, 56-60, PROF. & CHMN. DEPT, 60- U.S. Pub. Health Serv. sr. res. fel, 58-60; mem. physiol. training comt, Nat. Inst. Gen. Med. Sci, 71-; physiol. test comt, Nat. Bd. Med. Exam, 72- Med.C, U.S.A, 45-47. AAAS; Soc. Gen. Physiol; Am. Physiol. Soc; Am. Soc. Zool; Soc. Neurosci. Physiology of the nervous system. Address: Dept. of Physiology, State University of New York Upstate Medical Center at Syracuse, Syracuse, NY 13210.

STRANDJORD, Paul E., M.D.

Academy of Clinical Laboratory Physicians and Scientists

STRANDJORD, PAUL EDPHIL, b. Minneapolis, Minn, Apr. 5, 31; m. 53; c. 2. CLINICAL CHEMISTRY, LABORATORY MEDICINE. B.A, Univ. Minn, 51, M.A, 52; M.D, Stanford Univ, 59. Intern med, sch. med, Univ. Minn, 59-60, resident, 60-61, U.S. Pub. Health med. fel, 61-63, instr. LAB. MED, 63-64, asst. prof, 64-66, assoc. prof, 66-69; PROF. & CHMN. DEPT, SCH. MED, UNIV. WASH, 69- Borden Res. Award, Stanford Univ, 59; C.J. Watson Res. Award, Univ. Minn, 63. AAAS; Acad. Clin. Lab. Physicians & Sci; Am. Chem. Soc; Am. Fedn. Clin. Res; Am. Asn. Clin. Chem. Diagnostic enzymology; diagnosis of liver disease; pattern recognition; computer assisted diagnosis. Address: Dept. of Laboratory Medicine, University of Washington School of Medicine, Seattle, WA 98105.

YOUNG, Frank E., M.D., Ph.D.

Association of Medical School School Microbiology Chairmen

YOUNG, FRANK E, b. Mineola, N.Y, Sept. 1, 31; m. 56; c. 5. PATHOLOGY, MICROBIOLOGY. Union Col, 49-52; M.D, State Univ. N.Y, 56; Ph.D.(microbiol), Western Reserve, 62. Intern path, Univ. Hosps, Cleveland, Ohio, 56-57, res, 57-60; instr, Western Reserve, 62, asst. prof, 62-65; assoc. mem, depts. microbiol. & exp. path, Scripps Clin. & Res. Found, 65-68, mem, 68-70; PROF. MICROBIOL, PATH, RADIATION BIOL. & BIOPHYS. & CHMN. DEPT. MICROBIOL, SCH. MED. & DENT, UNIV. ROCHESTER, 70- Am. Cancer Soc. res. grant & faculty res. assoc, 62-; Nat. Insts. Health res. grant, 65, training grant, 70-; assoc. prof, Univ. Calif, San Diego, 67-70; dir. clin. microbiol. labs, Strong Mem. Hosp, 70-; dir, Health Dept. Labs, Monroe County, 70-; Nat. Sci. Found. Res. grant, 70- AAAS; Am. Soc. Microbiol; Am. Soc. Biol. Chem; Am. Soc. Exp. Path; Am. Asn. Path. & Bact. Mechanism of deoxyribonucleic and mediated transformation of bacterial and animal cells; regulation of bacterial cell surface; effect of heavy metals on DNA. Address: Dept. of Microbiology, School of Medicine & Dentistry, University of Rochester, Rochester, NY 14642.

AMENDMENT TO RULES AND REGULATIONS OF THE COUNCIL OF ACADEMIC SOCIETIES

The Administrative Board of the Council of Academic Societies has reviewed the experience with the procedure for nomination and election of CAS Administrative Board Members and Officers since the present system was instituted in 1971.

The current system is to elect the Nominating Committee at the time of the Annual Meeting from a slate made-up of those attending. The Nominating Committee selects a slate of nominees providing for twice the number of individuals as there are open positions in each category (Chairman-Elect, Basic Sciences, Clinical Sciences). Balloting provides for voting for a number equal to the number of open positions, and the individuals receiving the highest number of votes are elected.

The Administrative Board believes that the procedure should be simplified by eliminating the election of the Nominating Committee, and recommends amending Section V. Committees, Paragraph 1, of the CAS Rules and Regulations as shown below.

Section V. Committees

1. The Nominating Committee shall be comprised of seven members. The Chairman of the Administrative Board shall be the Chairman of the Nominating Committee and shall vote in the case of a tie. Six individuals (3 basic science and 3 clinical science) shall be appointed by the CAS Administrative Board from among representatives of the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board. The Nominating Committee shall meet to select a slate of officers prior to June 1st of the year of the election.

STATUS OF BIOMEDICAL RESEARCH LEGISLATION

On April 30, 1976, the President's Biomedical Research Panel reported its Congressionally authorized study of the status of the nation's biomedical and behavioral research effort. Both the Senate and House Health Subcommittees began a year-long series of oversight hearings on the function of the NIH with a discussion of the President's Panel Report. During the past year the 95th Congress, facing six expiring health related authorities, renewed each of these acts by extending the current authorities for one year. Included in this group of laws which directly affect biomedical research were the National Cancer Act; the National Heart, Lung, Blood and Blood Vessel Act; and the National Research Service Awards Act (research training).

The one year extensions of authority provided an opportunity for the Congress to focus on NIH oversight in greater detail; however, the legislators became preoccupied with recombinant DNA research legislation. Consequently, the health subcommittees have directed their oversight primarily to the areas of environmental, epidemiologic and health care research.

In anticipation of the postponed Congressional review of biomedical research and research training authorities during the next legislative sessions, the Association has appointed an ad hoc Task Force to assess present AAMC policy on the support of biomedical research and research training.

The task force is headed by CAS Chairman-Elect, Robert M. Berne, M.D., Chairman of Physiology at the University of Virginia. Task Force members representing the AAMC Council of Deans and the AAMC Council of Teaching Hospitals are Theodore Cooper, M.D., Ph.D., Dean, Cornell University Medical School (COD) and Charles A. Sanders, M.D., Director of Massachusetts General Hospital (COTH). In addition to the Chairman, other CAS representatives to the task force include Philip R. Dodge, M.D., Chairman of Pediatrics, Washington University; Harlyn Halvorson, M.D., Director, Rosenstiel Basic Research Center, Brandeis University; David B. Skinner, M.D., Chairman of Surgery, University of Chicago; Samuel O. Thier, M.D., Chairman of Internal Medicine, Yale University; and Peter C. Whybrow, M.B., B.S., Chairman of Psychiatry, Dartmouth.

The panel met in early October to study and update previous AAMC policy papers, identify new research policy issues, and develop an issues-and-position paper. After November task force review, the paper will be distributed to the CAS, providing member societies the opportunity to examine it thoroughly prior to the January interim meeting. The task force's final report will be presented to all AAMC Councils in March 1978.

Recombinant DNA Legislation

Seldom in recent years has the biomedical community shown such concern and concentrated action over legislation as it has over the bills which would regulate recombinant DNA research. The Senate bill (S.1217), sponsored by Senator Edward M. Kennedy (D-MASS.), was reported to the Senate floor on July 22. On August 2, Senator Gaylord Nelson (D-WIS.) introduced "an amendment in the nature of a substitute" to S.1217 which is decidedly preferable to the heavy-handed regulation of S.1217, differs from it on a number of major issues, and is believed to have the unofficial endorsement of the NIH. The AAMC, the American Society of Microbiology, and other organizations with unprecedented support of the scientific community contacted every senator to urge support for the Nelson substitute. At this time, Mr. Kennedy has withdrawn S.1217, and the House Bill (HR.7897) appears to be stalled in committee. We will continue our efforts to impress upon the Congress the concerns of scientists until the issue is finally resolved.

Clinical Laboratories Improvement Act

The AAMC has worked vigorously for changes in this Act which, in our opinion, will have at least two deleterious effects. First, it will increase hospital costs further by setting mandatory personnel requirements. Second, the legislation originally proposed would also inhibit the transfer of research-proven knowledge to patient care by requiring the licensing and hiring of special personnal in clinical research laboratories which also perform tests used for patient care. The AAMC, working with member societies, has held that whenever laboratory tests involve patients, the quality of these laboratory tests should certainly be assured; however, AAMC believes that the quality of the tests performed by clinical laboratories should be safeguarded by the Secretary, DHEW, who should have the discretion to adopt alternate standards appropriate to the research conducted in the laboratories. Member societies supported by AAMC staff have been instrumental in bringing the research laboratory problem to the attention of the Congressional committees. In late July, 1977, the Senate passed a version of the bill which would exempt clinical research laboratories from the provisions of the Act. It now appears likely that the companion House clinical laboratory bill (HR.6221) will also contain a provision exempting those clinical laboratories (or parts of laboratories) which perform research tests only. It appears that the Secretary, DHEW, will be allowed to decide whether clinical tests are research or routine. Though this may be difficult in some cases this approach seems preferable to a law which would spell out rigid requirements.

GRADUATE MEDICAL EDUCATION

In his address to the AAMC at the 1976 Annual Meeting, Eli Ginzberg characterized graduate medical education as the soft underbelly of medical education because it had evolved without a firm institutional foundation and without secure funding.

The focus of this year's Annual Meeting on Graduate Medical Education and the appointment of a Graduate Medical Education Task Force is evidence of the growing concern by the AAMC and its three Councils with this essential phase of physician education and training.

During the year there have been several significant developments, which will, in the future, affect graduate medical education.

Revision of General Requirements for Graduate Medical Education

Included in the agenda is a draft revision of the General Requirements for Graduate Medical Education. This revision is intended to replace Sections I through III in the Essentials of Approved Residencies.* Before acting on the revision and forwarding it to the Coordinating Council on Medical Education (CCME) and its sponsoring organizations for approval, the Liaison Committee on Graduate Medical Education (LCGME) is circulating this draft for advice and comment. It is important to recognize that the revision makes the responsibilities of institutions sponsoring graduate medical education much more explicit and, at the same time, reinforces the authority and responsibility of Residency Review Committees (RRCs) to determine the quality standards for educational programs in the various specialties. CAS member societies are encouraged to review and comment on the draft. It is anticipated that the LCGME will forward the revision to the Coordinating Council on Medical Education in the spring of 1978. Approval by the sponsoring organizations will require approximately one year, so that implementation of the new General Requirements will not begin until 1979.

Procedures and Staffing of the Liaison Committee on Graduate Medical Education and Residency Review Committees

There has been mounting pressure to upgrade the accreditation review process of programs in graduate medical education, and improve the staff support provided to Residency Review Committees and the Liaison Committee on Graduate Medical Education. The AAMC Executive Council has placed a high priority on the development of a separate, independent staff for RRCs and the LCGME, and has been joined by the American Board of Medical Specialties and the Council of Medical Specialty Societies. The LCGME at its September meeting recommended that its parent organizations establish a commission to review and modify the original agreement which established the LCGME. The agreement provided for

*Liaison Committee on Graduate Medical Education, Directory of Accredited Residencies, pages 333-339, 1975-1976.

the AMA to provide staff support to the LCGME "for the time being."

Changes in procedure which have been called for are: (1) A more flexible policy in the periodicity of review of programs, permitting strong programs to be reviewed at frequencies of five to six years, while weak programs would be reviewed at intervals deemed necessary to stimulate correction of identified deficiencies. This would be a departure from the rigid three-year period now in force. (2) Substituting site visitors who have knowledge of the specialty and the program being reviewed for the AMA field staff who now site visit programs. (3) Coordinating site visits so that all programs sponsored by an institution can be reviewed at the same time. (4) Improved documentation of Residency Review Committee actions and greater involvement of Residency Review Committee chairmen in articulating the criticisms of programs which are fed back to program directors and their institutions by the RRCs. The size and characteristics of a separate staff will have to be based upon procedural changes in the accreditation process. The revenue to support such a staff will have to be derived from charges to institutions for program review. This could raise the charges from their current level of $300.00 per program to $1,000.00 per program or more.

Many of the concerns expressed by certifying boards and specialty societies about their difficulties in modifying educational standards and policies cannot be resolved solely by establishing an independent staff for the RRCs and the LCGME. Each of the twenty-three Residency Review Committees is co-sponsored by the American Medical Association, and all changes in special requirements for each specialty must be approved by the House of Delegates of the AMA. Member societies of the CAS should consider whether continuation of this dominance of the RRCs by one professional organization is appropriate.

Foreign Medical Graduates

Public Law 94-484 placed major limitations on the continued immigration of alien graduates of foreign medical schools. In addition to requiring foreign graduates to pass an exam equivalent to Parts I and II of the National Board exam, the law requires that there be interinstitutional agreements for each student entering graduate medical education between a U.S. school and its affiliated hospital, and an institution or agency in the student's home country. A waiver clause is provided so that institutions which anticipate serious disruption in their ability to provide medical services can seek exemption and continue to appoint physicians who have not been able to pass the exam, and avoid entering into bilateral agreements.

The NBME gave the first Visa-Qualifying Exam to about 5,000 physicians in September, 1977. Within the next month, the Board will announce the outcome of the exam and will publish the policies and procedures relative to its administration and scoring. It is likely that there will be a significant decrease in the number of FMGs who will enter graduate medical education programs in 1978 and future years.

Presently a blanket waiver from the provisions of the Act is in effect until January of 1978. How many requests for substantial disruption waivers will be forthcoming is not at present known. The LCGME has expressed its intent to do special reviews of graduate medical education programs that request a waiver on the basis of substantial disruption in the provision of medical services.

Housestaff Unionization

Subsequent to the National Labor Relations Board 1976 ruling that housestaff are primarily students, and therefore not included under the provisions of the 1974 amendments to the National Labor Relations Act which extended this Act to include employees of non-public hospitals, the Physicians National Housestaff Association and the Resident Physician Section of the AMA (supported by the House of Delegates of the AMA) have endeavored to overturn this ruling. Legislation has been introduced in both Houses of Congress to declare that housestaff are to be included as employees and shall be provided the opportunity to bargain collectively under the rules established by the National Labor Relations Board. Hearings were held in the spring of 1977 by Representative Thompson (D-NJ) and his Subcommittee in the House on H.R. 2222. In September, Senator Riegle (D-Michigan) and Senator Cranston (D-Ca) introduced a companion bill in the Senate, S. 1884. Hearings have not been held on the Senate bill. Meanwhile, the U.S. Court of Appeals in a New York case has established the preemptive authority of the NLRB ruling over contrary rulings by state labor relations boards.

The AAMC is opposing the legislative proposals and has participated as an amicus in several legal proceedings on this issue.

DRAFT

THE ESSENTIALS OF GRADUATE MEDICAL EDUCATION

prepared and submitted by the

Committee on Essentials

Liaison Committee on Graduate Medical Education

August G. Swanson, M.D. (AAMC), Chairman

James W. Haviland, M.D. (AMA)

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July 25, 1977

DRAFT
7/25/77

FOREWORD

THE COORDINATING COUNCIL ON MEDICAL EDUCATION AND ITS LIAISON COMMITTEES

The Coordinating Council on Medical Education (CCME)* was established in 1973 through the agreement of five sponsoring professional organizations. These are the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), and the Council of Medical Specialty Societies (CMSS). Each organization has three seats on the Council.

The Coordinating Council is responsible for coordinating the activities of the three Liaison Committees which have accreditation authority over the undergraduate, graduate, and continuing phases of medical education. The Council also reviews and perfects major policy recommendations and submits agreed-to changes in policy to the five sponsoring organizations, all of which must give approval to policies before they are implemented.

Accreditation of undergraduate medical education is the responsibility of the Liaison Committee on Medical Education (LCME), which was established in 1942. The Association of American Medical Colleges and the American Medical Association each have six seats on the LCME; in addition, there are two public members and a representative of the federal government.

The Liaison Committee on Graduate Medical Education (LCGME) was formally implemented in 1975. The Association of American Medical Colleges, the American Board of Medical Specialties and the American Medical Association each have four seats on the LCGME. The American Hospital Association and the Council of Medical Specialty Societies each have two seats. In addition, there are one public member, one resident physician member, and a representative of the federal government.

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*The address of the Coordinating Council is: Coordinating Council on Medical Education, Office of the Secretary, P.O. Box 7586, Chicago, Illinois 60610

The Liaison Committee on Continuing Medical Education (LCCME) was formally implemented in 1977. The American Medical Association has four seats on the LCCME. The Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies each have three seats. The Association of Hospital Medical Educators and the Federation of State Medical Boards each have one seat. In addition, there are one public member and a representative of the federal government.

Each Liaison Committee has accreditation policies and procedures germane to the phase of medical education for which it is responsible.

The Liaison Committee on Graduate Medical Education oversees the policies and procedures of the several Residency Review Committees (RRCs) and after review of RRC recommendations issues letters of accreditation to approved programs and their institutions. The LCGME is also responsible for the development of the policies set forth in the General Requirements for Graduate Medical Education and implements those policies after approval by the five sponsoring professional organizations.

The LCGME also reviews and approves the Special Requirements developed by each Residency Review Committee. The RRCs submit these to the LCGME after they have been reviewed and approved by the sponsors of the RRC. The Residency Review Committees and their sponsors are:

RRC	Sponsoring Organization
Allergy & Immunology	AMA Council on Medical Education American Board of Allergy & Immunology
Anesthesiology	AMA Council on Medical Education American Board of Anesthesiology
Colon & Rectal Surgery	AMA Council on Medical Education American Board of Colon & Rectal Surgery American College of Surgeons

RRC	Sponsoring Organization
Dermatology	AMA Council on Medical Education American Board of Dermatology
Family Practice	AMA Council on Medical Education American Board of Family Practice American Academy of Family Practice
General Practice	AMA Council on Medical Education American Academy of Family Practice
Internal Medicine	AMA Council on Medical Education American Board of Internal Medicine American College of Physicians
Neurological Surgery	AMA Council on Medical Education American Board of Neurological Surgery American College of Surgeons
Nuclear Medicine	AMA Council on Medical Education American Board of Nuclear Medicine
Obstetrics-Gynecology	AMA Council on Medical Education American Board of Obstetrics-Gynecology American College of Obstetrics-Gynecology
Ophthalmology	AMA Council on Medical Education American Board of Ophthalmology
Orthopedic Surgery	AMA Council on Medical Education American Board of Orthopedic Surgery American Academy of Orthopedic Surgery
Otolaryngology	AMA Council on Medical Education American Board of Otolaryngology American College of Surgeons
Pathology	AMA Council on Medical Education American Board of Pathology
Pediatrics	AMA Council on Medical Education American Board of Pediatrics American Academy of Pediatrics
Physical Medicine & Rehabilitation	AMA Council on Medical Education American Board of Physical Medicine & Rehabilitation

RRC	Sponsoring Organization
Plastic Surgery	AMA Council on Medical Education American Board of Plastic Surgery American College of Surgeons
Preventive Medicine	AMA Council on Medical Education American Board of Preventive Medicine
Psychiatry & Neurology	AMA Council on Medical Education American Board of Psychiatry & Neurology
Radiology	AMA Council on Medical Education American Board of Radiology
Surgery	AMA Council on Medical Education American Board of Surgery American College of Surgeons
Thoracic Surgery	AMA Council on Medical Education American College of Surgeons American Board of Thoracic Surgery
Urology	AMA Council on Medical Education American Board of Urology American College of Surgeons

ESSENTIALS OF GRADUATE MEDICAL EDUCATION

PREAMBLE

These Essentials of Graduate Medical Education set forth the requirements that institutions and programs sponsoring graduate medical education must meet in order to be accredited by the Liaison Committee on Graduate Medical Education (LCGME)* They are divided into (I) General Requirements, which delineate institutional responsibilities and broad general principles common to all programs in graduate medical education, and (II) the Special Requirements for each specialty. The Special Requirements detail the content and scope of education and training which must be provided by programs to physicians seeking to qualify for certification in a particular specialty.

Accreditation of Graduate Medical Education

Accreditation of institutions sponsoring graduate medical education is a voluntary service conducted by the Liaison Committee on Graduate Medical Education and the Residency Review Committees to ensure that they and the programs they offer meet acceptable standards of quality. The voluntary specialty certifying boards that are members of the American Board of Medical Specialties require that education and training qualifying individuals to seek certification in their specialties be obtained only in programs accredited by the LCGME. Exceptions to this requirement are occasionally granted by certifying boards on a case-by-case basis.

The Continuum of Medical Education

Undergraduate Education:

The education and training of physicians in the United States begins with their entrance into a school of medicine as candidates for the degree of Doctor of Medicine. The undergraduate phase,

*The address of the LCGME is: Liaison Committee on Graduate Medical Education, Office of the Secretary, 6th Floor, 535 North Dearborn Street, Chicago, Illinois 60610

which leads to the M.D. degree, is accredited by the Liaison Committee on Medical Education (LCME) and is preparatory for graduate medical education as indicated in this statement from the LCME's "Structure and Functions of a Medical School":

> *"The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects."*

During the undergraduate phase, students gain knowledge of the sciences basic to medicine and learn to apply that knowledge to clinical problems. Skills in collecting data are developed by interviewing and examining patients and applying laboratory procedures under the guidance and supervision of the faculty and residents. Students learn to utilize these data to arrive at diagnostic hypotheses and make therapeutic decisions. These basic skills are learned by rotations through a variety of clinical disciplines in both inpatient and outpatient settings. Undergraduate students have limited opportunities to assume personal responsibility for patient care, and do not participate in the care of individual patients for an extended period of time.

Graduate Education:

By the time the M.D. degree is awarded, most graduates have made decisions regarding their further professional development and enter the phase of their education which is termed graduate medical education with the intent to prepare themselves for the practice of medicine in a specialty. For most, this means completing the special educational requirements for certification by a specialty board. A few enter practice before meeting these requirements. Others, after completing the requirements of a primary board, enter into additional training in order to achieve recognition of special competence in a subspecialty.

Physicians who choose to pursue graduate medical education acknowledge their need for education and training beyond the minimum legal standard established by state and territorial laws and regulations, which generally permit physicians to be licensed upon completion of their first year of graduate medical education. The term "resident physicians" has been applied to those in clinical graduate medical education.

In the graduate phase, residents first assume limited, personal responsibility for patient care under the supervision of faculty physicians. The opportunity to learn about the variability of human beings in health and disease, and about their biological, psychological, and social problems is provided through direct and continuing responsibility in caring for many patients. Effective graduate medical education requires that residents gain knowledge, skill, and experience, and a progressive increase in their personal responsibility for patient care in a setting which always provides for systematic supervision by responsible faculty.

Continuing Medical Education:

Postgraduate or continuing medical education is the term applied to the phase of medical education which extends from the completion of formal graduate medical education throughout the professional life of physicians. It is based on a variety of educational strategies ranging from independent study through attendance at formal lectures and participation in seminars to medical audit.

Transition Between Undergraduate and Graduate Medical Education:

The transition from being an undergraduate medical student to the assumption as a resident of an increasing degree of personal responsibility for patient care is a critical period in the professional development of every physician.

This period is made even more critical because most residents are taking their first step toward differentiating into one of the

specialty careers available in the practice of medicine. Throughout the first year of graduate medical education (the G-1 year), special efforts should be made by the teaching staff to determine whether the career aspirations of residents are realistic, and whether they have a sufficient breadth of knowledge and experience to undertake education and training in their chosen field. Career counseling should be provided in order to ensure that residents are guided appropriately.

First year graduate medical (G-1) programs of two types are available to residents at the transition. These are:

Categorical: These G-1 programs are based on the special requirements of a specialty, are principally provided by the teaching staff of a single program, and predominantly provide an educational experience in that specialty. Rotations in other clinical areas may be permitted or expected.

Diversified: These G-1 programs are based on the special requirements of two or more specialties, are provided by the teaching staffs of two or more programs in an institution, and prepare residents to enter at the G-2 level of the specialties sponsoring the diversified program.

I. GENERAL REQUIREMENTS

1. Institutional Responsibility for Graduate Medical Education

The principal institutions which provide programs in graduate medical education are teaching hospitals and the medical schools with which they may be affiliated. Health-related organizations and agencies may also participate. Whatever the institutional form, the LCGME requires that there be a firm institution-wide commitment to medical education. The following policy statement was approved by the sponsoring professional organizations of the CCME in 1974.

> *"Institutions, organizations and agencies offering programs in graduate medical education must assume responsibility for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.*
>
> *While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must insure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.*
>
> *The governing boards, the administration, and the teaching staffs must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training.*

Facilities and teaching staff shall be appropriate and sufficient for effective accomplishment of the educational mission of each program. If outside facilities or staff are needed to fulfill program needs, the primary sponsor must maintain full responsibility for the quality of education provided."

Graduate medical education is conducted in institutional settings wherein there are invariably several missions. Providing clinical services of the highest quality must be the principal mission of hospitals and clinics sponsoring programs in graduate medical education. The range and scope of primary and ancillary clinical services must be sufficient to provide educational opportunities consistent with modern medical practice. All of those who use institutions and their resources for graduate medical education are expected to collaborate to ensure that all institutional missions are achieved, particularly excellence in patient care.

Institutions sponsoring programs in graduate medical education must undertake the educational mission fully aware that the education of resident physicians requires the provision of patient care by residents. However, a commitment to education must supercede any intent to expedite the provision of services. Patient care can be provided in the absence of an educational program, but a sound educational program necessitates involving residents in progressive levels of personal responsibility for patient care under supervision.

Accreditation of graduate medical education programs requires that institutions meet the standards set forth in these general requirements and that each specialty program meet the standards set forth in the special requirements for that specialty*

*Recognizing that the requirements for establishing institutional responsibility will necessitate considerable modification of present policies and procedures in most institutions, the LCGME intends to develop a phased program of implementation which will provide sufficient time to adapt to these new requirements.

1.1 The LCGME requires that institutions sponsoring programs in graduate medical education provide documentary evidence of a commitment to medical education by:

a) the institutional governing board
b) the institutional administration
c) the teaching staff
d) the organized medical staff

This evidence shall consist of:

1.1.1 A written statement setting forth the purposes for which the institution sponsors graduate medical education. There must be tangible evidence of agreement to this statement by the teaching staff, the organized medical staff, and the administration. The statement must be agreed to and approved by the governing board.

1.1.2 A detailed plan which sets forth how institutional resources are organized and distributed for educational purposes. Such resources include teaching staff, patients, physical facilities and financial support. There must be clear evidence that the plan is agreed to by the administration, program directors, and the organized medical staff, and approved by the governing board. Those responsible for administration of the plan must be identified by name and title in the institution's table of organization.

1.1.3 An operational system, based on institutional policies, established and implemented for graduate medical education programs deemed appropriate for the institution to provide for:

a) the appointment of teaching staff;
b) the selection of residents
c) the apportionment of residents among programs;
d) the evaluation, promotion, and graduation of residents;
e) the development and publication of personnel policies applicable to residents;
f) the termination of residents whose performance is unsatisfactory;
g) the assurance of due process for residents and teaching staff.

These policies must be agreed to by the administration and teaching staff, incorporated in a manual of policies and procedures, and reviewed and approved by the governing board. Further, there must be clear evidence of adherence to these policies and procedures.

1.1.4 An operational system for periodic internal analysis of each sponsored program by the teaching staff, residents, and administration. Such analyses shall include critical appraisal of:

a) the goals and objectives of each program;
b) the instructional plan formulated to achieve these goals;
c) the effectiveness of each program in meeting its goals, including the performance of enrolled residents on examinations.

There must be clear evidence that analyses are effective, and that mechanisms exist to correct identified deficiencies.

Institutions sponsoring more than one program should provide administrative mechanisms for the coordination of the activities of the teaching staffs of all of the programs in the institution.

Documentation of items 1.1.1 through 1.1.4 must be maintained within the institution in some central place ready for periodic review by the LCGME and the RRCs through assigned site visitors. Evidence of failure by a program to comply with established and approved institutional policies will jeopardize the accreditation of that program. Evidence of institutional failure to implement its established policies will jeopardize the accreditation status of all programs.

When significant modifications in institutional policies, programs, or teaching staff occur between LCGME accreditation reviews, institutions must report the nature and magnitude of such changes to the LCGME.

1.2 Interinstitutional agreements: When the resources of two or more institutions are utilized for the conduct of one or more programs, each participating institution must demonstrate a commitment to graduate medical education and will be required to submit the evidence set forth in 1.1.1 through 1.1.4

The following items must be covered in interinstitutional agreements. Documentary evidence of agreements, approved by institutional

governing boards must be available for inspection by assigned site visitors.

1.2.1 Items of agreement:

a) Designation of program director: A single director for each program must be designated. The scope of the director's authority to direct and coordinate the program's activities must be clearly set forth in a written statement.

b) Teaching staff: The teaching staff responsible for providing the educational program and supervising the residents must be designated.

c) Educational contribution: The expected educational experiences to be provided by each institution to each program must be delineated.

d) Assignment of residents: The period of assignment of residents to the segment of a program provided by each institution and any priority of assignment must be set forth.

e) Financial commitment: Each institution's financial commitment to the direct support of each program must be specifically identified. Such commitment should include residents' stipends, reimbursement of teaching staff, and provision of monies for books, teaching equipment, etc. Agreements should provide for an equitable distribution of the financial support for all sponsored programs among the participating institutions.

f) Other: Fringe benefits and special privileges for residents should be as consistent as possible from institution to institution.

1.2.2 When several institutions participate in sponsoring multiple programs, administrative mechanisms should be developed to coordinate the overall educational mission and facilitate the accomplishment of the policies and procedures set forth in subsections 1.1 and 1.2.

1.3 Facilities and Resources: Institutional facilities and resources must be adequate to provide the educational experiences and opportunities set forth in the special requirements for each sponsored program. These include, but are not limited to, an adequate library providing access to standard reference texts and current journals, sufficient space for instructional exercises, adequate facilities for residents to carry out their patient care and personal educational responsibilities, and a patient record system which facilitates both good patient care and education.

1.4 Hospital Accreditation: Hospitals sponsoring or participating in programs of graduate medical education are expected to seek and attain accreditation by the Joint Commission on Accreditation of Hospitals. If a hospital is not so accredited, the reasons why accreditation was not sought or was denied must be explained and justified in the materials submitted for review by the RRCs and the LCGME.

2. *The Teaching Staff*

The individuals who have responsibility for the conduct of graduate medical education programs must be specifically identified. These should include physicians, basic scientists, and other health professionals.

2.1.1 The program director: The director should be recognized as highly skilled in the appropriate medical field, with a clear commitment to education and the advancement of knowledge. The director should have an institutional position which provides the authority and time needed to fulfill administrative and teaching responsibilities, and to achieve the educational goals of the program.

2.1.2 Teaching staff: The teaching staff should consist of members of the medical staff with institutional positions and those who voluntarily participate in the educational programs. They should be selected for their abilities to con-

tribute to the educational goals and objectives of the programs and should have sufficient time to discharge their responsibilities.

2.1.3 Other health professionals: Graduate medical education requires that the activities of all involved health professionals be integrated in the care of patients. The medical teaching staff with the primary responsibility for educational programs should involve other health professionals in its programs.

2.2 Relationships between medical staff and teaching staff: In some institutions the organized medical staff and the teaching staff are differentiated. Where this is the case, the institutional educational plan (1.1.2) must clearly delineate the agreements reached regarding the utilization of institutional resources for education. This must include agreement relating to the contact of residents and teaching staff with the patients of members of the organized medical staff not involved in the teaching program.

3. *Resident Physicians*

Resident physicians with the following qualifications are eligible to enroll in graduate medical education programs accredited by the LCGME.

3.1 Unrestricted eligibility: Unrestricted eligibility is accorded to those with the following qualifications:

3.1.1 Recipients of the M.D. degree granted by institutions in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME).

3.1.2 Recipients of the D.O. degree granted by institutions in the U.S. accredited by the American Osteopathic Association, unless prohibited by Special Requirements.

3.1.3 Recipients of the M.D. degree (or its equivalent) from foreign medical schools not accredited by the LCME who meet the following additional qualifications:

a) Have been granted the privilege to practice medicine in the country of the institution granting the degree, have passed an examination designated as acceptable by the LCGME, and have had their credentials validated by an organization or agency acceptable to the LCGME; or,

b) Have a full and unrestricted license to practice medicine in a U.S. jurisdiction providing such licensure.

3.1.4 In the case of U.S. citizens:

a) Have successfully completed the licensure examination in a jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted after successful completion of a specified period of graduate medical education; or,

b) Have completed in an accredited U.S. college or university undergraduate premedical education of acceptable quality, have successfully completed all of the formal educational requirements of a foreign medical school, but have not been granted the privilege to practice medicine by the country in which the medical school is located by reason of not having completed a period of required service, and have passed an examination designated as acceptable by the LCGME.

3.2 Restricted eligibility: Restricted eligibility for foreign nationals to enroll in LCGME programs is accorded under the following circumstances:

a) When a U.S. medical school and one or more of its affiliated hospitals have a documented bilateral agreement, approved by an agency recognized for that purpose by the LCGME, with an official agency or recognized institution in the resident's country of origin to provide an educational program designed to prepare the resident to make specific contributions in the health field upon return to the country in which the sponsoring agency or institution is located; and,

b) The resident has been accorded the privilege to practice medicine in the country wherein the agency or institution making the agreement referred to in (a) is located; and,

c) The resident has passed examinations designated as acceptable by the LCGME for determination of professional preparedness and fluency in the English language; and,

d) The resident has made a formal commitment to return to the country in which the sponsoring agency or institution is located; and,

e) The credentials of the resident and the existence of a suitable agreement have been validated by an organization or agency acceptable to the LCGME.

Restricted eligibility shall be limited to the time necessary to complete the program agreed to by the parties as referenced in (a), without regard as to whether such agreement fulfills the requirements for certification by a specialty board.

3.3 The enrollment of non-eligibles: The enrollment of non-eligible residents may be cause for withdrawal of accreditation by the LCGME.

3.4 Selection and recruitment: It is expected that institutions and their sponsored programs will select residents with due consideration for their preparedness to enter into the graduate medical education programs that they have selected. Criteria for selection of residents should include personal characteristics as well as academic credentials.

In selecting G-1 residents, institutions are encouraged to participate in The National Intern and Resident Matching Program (NIRMP)*. Participating institutions should ensure that all of their sponsored programs adhere to the principles and policies established by NIRMP.

The NIRMP is a voluntary agency sponsored by: American Hospital Association, American Medical Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Student Association, and American Board of Medical Specialties.

The recruitment of residents by institutions and programs is premature when it causes students to make career decisions before they or their medical schools have been able to evaluate their interest in, or fitness for, a particular specialty; such early recruitment is strongly discouraged.

4. Relationships Between Institutions and Residents

Resident physicians are expected to have an unreserved commitment to the professional responsibilities expected of all physicians by society. Institutional policies relative to residents' responsibilities must be made available to applicants prior to their making a decision to seek enrollment in a sponsored program.

4.1 Residents' responsibilities: Being an enrolled resident physician in an accredited program of graduate medical education requires the assumption of responsibility for:

a) Participation in the institutional programs and activities involving the medical staff and adherence to established practices and procedures;

b) The provision of medical services, under supervision, to the patients who seek such services from the institution; and,

c) Participation in the formal instructional program presented by the teaching staff; and,

d) The supervision and instruction of medical students and more junior resident physicians; and,

e) The development of a personal program of self-study and professional growth.

4.2 Agreements with enrolled residents: There should be an individual written agreement between the institution and each resident enrolled in its sponsored program. Parties to this agreement should be the program director, the individual designated as having institutional authority, and the resident. The agreement should encompass the following:

4.2.1 Stipend: If a stipend is provided by or administratively managed by the institution, the annual stipend level and other benefits should be stated. The purpose for which the stipend is provided should be stated.

4.2.2 Programmatic requirements: The responsibilities of the resident in the educational program, including independent study, patient care responsibilities, on-call responsibilities, teaching and supervisory responsibilities, and periods of assignment to participating institutions should be detailed.

4.2.3 Evaluation and promotion: The institutional policies and procedures for evaluation and promotion of residents should be clearly stated and the rights of residents to due process in the review and determination of the adequacy of their performance should be delineated.

4.2.4 Other elements: The agreement should clearly state institutional policies for:

a) vacation, professional leave, and sick leave;
b) practice privileges outside the educational program;
c) malpractice coverage.

4.2.5 Individualized programs: Individualized educational plans, such as a reduced schedule or educational opportunities tailored to meet a resident's career development aspirations, must be specified. General agreements arrived at through any collective negotiation between residents and the institution must not inhibit the development of programs to meet the individual needs of residents.

4.3 Due Process: Institutions sponsoring graduate medical education programs must have a written procedure which provides an opportunity for residents to appeal actions by the staff or administration when such actions are perceived to threaten the resident's intended career development. This procedure must be agreed to by the teaching staff and administration and be reviewed and approved by the governing board.

4.4 Reporting requirements: Institutions sponsoring accredited programs in graduate medical education must report annually the names of individuals enrolled in their programs, the institutions from which they received their M.D. degree (or equivalent), the program in which they are currently enrolled, and the program in which they were enrolled for the previous year; in addition, institutions must report those individuals successfully completing their sponsored programs. These reports shall be supplied to the LCGME and to agencies designated by the LCGME as having responsibility for the recording of credit and the collection and analysis of data on physician manpower and development.

5. Relationships Between Teaching Staff and Residents

Medical education requires a collegial atmosphere wherein all who are involved have the common goals of serving the needs of the patients who seek care and advancing the quality of medical practice. The professional development of residents as they advance through the continuum of medical education requires that there be a relationship of mutual respect and understanding between and among them, their teachers, and those whom they themselves teach. Building such a relationship and maintaining such an atmosphere is preeminently the responsibility of the teaching staff. Institutional administrators and governing boards must support these policies and provide the resources needed to promote a harmonious educational environment.

5.1 Supervision: Graduate medical education must be based upon the assignment to residents of increasing levels of personal responsibility for patient care in accordance with their experience and growing competence. On the other hand, there must be continuous supervision of all residents at all levels at all times. The plan for supervision must provide for regular and systematic review of the actions and decisions made by residents through clinical rounds and tutorial sessions. Review of performance and progress must be provided to residents at frequent intervals. Residents who are insecure about their abilities to assume or discharge responsibilities

to patients have a professional obligation to request additional supervisory assistance at any time, and members of the teaching staff are obligated to respond promptly to such requests. The development of a supervisory relationship embodying mutual respect and trust is imperative. Residents who consistently fail to seek assistance when they are faced with problems beyond their abilities must demonstrate that they can respond to corrective action or, if need be, must be terminated from their program.

5.2 Teaching and learning: An environment wherein both the teaching staff and the residents are seeking to improve their knowledge and skills is essential. Senior residents are expected to assume responsibility for teaching junior residents and medical students. The teaching staff is expected to organize formal teaching sessions tailored to meet the special requirements of their sponsored programs. Participation in these sessions by teaching staff from other clinical specialties and by teaching staff from the basic science disciplines is encouraged.

5.3 Formative evaluation: Formative or "in-training" evaluation is encouraged. Evaluation instruments may be prepared by the teaching staff, or the "in-training" examinations developed by certifying boards or specialty societies may be used.

5.4 Evaluation conferences: Periodically, and at least annually, members of the teaching staff must organize conferences to evaluate the performance of each enrolled resident. Participants in these evaluation sessions should include the program's teaching staff, residents with supervisory responsibility for more junior residents, and teaching staff from other programs with which the residents interact. A summary of the evaluation of each resident's performance must be discussed with the resident.

Evaluation summaries must be kept on file by program directors and by the institutional administration. The summaries must be available for inspection by the LCGME through its assigned site visitors and be accessible to the resident.

HOSPITAL COST CONTAINMENT

President Carter announced his proposed "Hospital Cost Containment Act of 1977" on April 25th. The proposed program is a "transitional" but non-expiring limitation which would apply to the inpatient revenues of non-Federal, acute care hospitals. Using a total revenue formula, the limitation would be applied on a per admission basis to patient revenues classified and separated by type of payor. HEW projects that use of the formula would result in an annual percentage increase in revenue limitation of approximately 9 percent for covered hospitals. The President's proposal would establish an annual nationwide ceiling of $2.5 billion for hospital capital expenditures and would establish standards for hospital bed supply and occupancy. The proposal was introduced in the Congress by Senator Kennedy (D-Mass.), S. 1391, and by Reps. Rogers (D-Fla) and Rostenkowski (D-Ill.), H.R. 6575.

On May 5th, Senator Herman Talmadge (D-Ga), introduced S. 1470 which includes provisions for hospital reimbursement, practitioner reimbursement, long-term care reimbursement, and program administration reforms. The hospital payment provisions include proposals to: classify hospitals into groups by bed size and type of hospital; establish reimbursement limitations for routine operating costs; exclude from routine operating costs capital and related costs, direct personnel and supply cost of hospital education and training programs, cost of interns and residents, costs of non-administrative physicians, heating and cooling energy costs and malpractice insurance expenses; adjust operating cost limitations for area wage differentials, and provide exception procedures for the effects of an atypical diagnostic case-mix.

During the summer, Senator Talmadge directed his staff to develop ways to have the bill take effect earlier and expand its coverage to include more than Medicare and Medicaid patients and more than adjusted routine operating costs. In September, the Senator announced an outline for the expanded version. The proposal would establish annual limits on the amount of revenue for the care of patients which short-stay hospitals could collect and retain. The revenue limits would be applied to hospitals' accounting periods which begin on or after July 1, 1978. The limits would apply to a hospital's inpatient care revenues from all payors. The routine revenue limitation would be applied on a per diem basis while the ancillary revenue limitation would apply on a per admission basis. Separate revenue limits would be calculated for the hospital's routine services (bed, board, routine nursing and supplies, etc.) and for its ancillary services (X-rays, laboratory tests, drugs, etc.). If a given hospital's revenue exceeded only one of the two limits, the excess revenues could be reduced to the extent they fell below the other limit.

The Association opposes the arbitrary nature of the Administration's flat revenue cap and objected to the inherent inequity of imposing a cap on hospital revenues when no other segment of the economy is similarly controlled. At least five components of the proposed bill threaten teaching hospitals: (1) it provides no mechanism for necessary additional revenues resulting from changes in diagnostic case mix; (2) it does not provide the additional revenues necessary to meet the residency needs of expanded medical school graduates and to provide new opportunities in primary care training; (3) it will severely hamper the ability of teaching hospitals to recruit salaried staff physicians; (4) by requiring virtual insolvency in order to obtain an exception, it may require hospitals to liquidate endowments; and (5) it provides no appeal mechanism for any hospital subject to an operational review which finds that the binding recommendations for improving the efficiency or economy of patient care services undermine teaching and tertiary care. In lieu of the proposed revenue limitations, the Association recommends a six-point program to moderate hospital costs; (1) uniform cost reporting system, (2) publication of hospital financial data, (3) cost impact statements for hospital legislation, (4) promotion and expansion of PSRO and health planning programs, (5) development and implementation of prospective payment limitations, and (6) promotion of state rate and budget reviews.

The AAMC objects to the permanent and arbitrary limits on hospital capital expenditures, bed supply and occupancy levels. Rather than the proposed limits of Title II, the Association supports full implementation and strengthening of the health planning law and Certificate of Need programs, and the establishment of positive incentives for providers to bring health care facilities and services in line with community needs.

The Association has been generally supportive of the original Talmadge Bill and acknowledges that hospital payment limitations derived from cross-classification are one legitimate approach to containing expenditures for hospital services. However, the AAMC recommends modifying the bill to provide more flexible provisions, amending the bill to ensure that faculty physicians could be paid for either professional or educational services when providing care in the presence of students and opposed payment mechanisms which would inhibit the development of a discipline, and recommends that the Secretary of HEW initiate studies to adequately define "tertiary care/teaching" hospitals and examine the impact of establishing a special payment category for these hospitals.

The Association has presented its position on the Administration and Talmadge proposals in testimony before House and Senate committees considering them. Association staff also have been meeting with staff of the various Subcommittees to discuss viable alternatives to the Carter proposal and ways of improving the Talmadge bill.

From a faculty perspective, the significant problem is the indirect effects of placing a ceiling on hospital reimbursements whether the mechanism used is that proposed by the Administrator or by Senator Talmadge. Once ceilings are in place, decisions about hospital expenditure priorities will be more sharply in focus, and intense and painful competition will ensue within institutions, if it hasn't already. Residency positions and programs will have to compete for dollars between the various specialty departments and sections, with other service programs, and with other capital and equipment acquisitions.

INTERIM MEETING/CAS PUBLIC AFFAIRS REPRESENTATIVES

In recent years CAS member societies have become increasingly active in public affairs. Partly in response to these interests, the CAS Public Affairs Representative system was initiated in 1976. A workshop, attended by representatives of 36 societies, was held to familiarize them with the legislative and public policy-making process at the federal level. Several conferences have been held in the past year to deal with specific policy questions and legislative items.

Forty-eight societies were represented at the CAS Interim Meeting in Washington, D.C. on June 22. A vigorous discussion of current policy issues in biomedical research, medical education and health care involved all of the participants. A leading issue at that meeting was legal restraint on the freedom of inquiry as framed in the recombinant DNA research legislative proposals then before both Houses of Congress. As a result of that discussion and the efforts of individual CAS representatives acting through their member societies, approximately 500 letters were received by congressional staff involved with this important legislation. Very significant modification of the DNA legislation resulted and a much more careful look is now being taken by the Congress at the issue of the limitation of research.

The next CAS Interim Meeting is scheduled for Wednesday, January 18, 1978, at the AAMC offices on Dupont Circle. The AAMC Task Force on Biomedical Research is now drafting a revision of AAMC policy position on the support of biomedical research and research training. The draft will be distributed to CAS member societies for comment and discussion during the Interim Meeting in January. As a result of this discussion, the draft will be further revised and presented to the Administrative Boards and Councils of the Association at their March, 1978 meeting.

Forty-one societies have now appointed a Public Affairs Representative. These individuals have been chosen for their interest in public policy development and their willingness to serve over an extended number of years as the principal interface between their societies, the CAS, other member societies, and public policy makers.

Societies which have not yet appointed Public Affairs Representatives are urged to do so as soon as possible.

CAS SERVICES PROGRAM

On August 1, 1977 the Association of American Medical Colleges initiated a two-year experimental program of increased services to member societies of the Council of Academic Societies. Its purpose is to provide to CAS member societies services they need to accomplish their missions and goals and to develop a closer relationship between the member societies and the AAMC.

The Services Program is administered through the Division of Biomedical Research of the Department of Academic Affairs. It was prompted by the AAMC's desire to initiate more effective communications with CAS societies and their members. The range of policy interests of the sixty CAS societies is extensive, and AAMC wishes to be more aware of the particular concerns of individual organizations. AAMC will then be able to report on legislative and executive branch actions which will affect society interests. Hopefully, better two-way communication will result which will strengthen AAMC's representation of CAS societies as well as improve individual societies' policy-making functions on behalf of their own members' interests.

In addition to the policy issue activities, there are a number of other services which can be offered on a direct cost basis: (1) Meeting arrangements - Meetings of the entire membership of societies or executive groups may be arranged; (2) Membership rosters - The maintenance and updating of membership lists can be provided using the AAMC computer facility; (3) Publications and mailings - Mailing labels can be generated and AAMC publications (e.g., Weekly Activities Reports, CAS Briefs and Alerts) can be mailed directly; (4) Special publications - Newsletters, reports, summaries and analyses can be prepared, edited, assembled and mailed as necessary; (5) Telecommunication links - Telephone and other rapid communication systems can be installed and manned; (6) Special services - As desired special services tailored to the needs of societies can be furnished. These could include, for example, accounting services, dues billing, maintenance of financial records, arranging for external audit, filing of tax returns, computer programming, conduct of special surveys, and creation of data bases.

Staffing costs to individual societies depends upon the amount of services required, but by sharing staff two or three societies can achieve their needs efficiently. During the experimental two years, the AAMC will charge no overhead costs (e.g. rent, heat, contributions to the effort by other AAMC staff) and will provide the funds needed to support the direct staff efforts which are not covered by participating societies. Whether the program will extend beyond the two year experimental period will be based upon judgment of the satisfaction of the societies with the services provided and of its

effectiveness in strengthening the accomplishments of the Association's responsibility to all its constituents. After June 1979, participant societies will be expected to meet overhead costs as well as staff and other direct costs.

The Association of Professors of Medicine is the first CAS organization to embark upon this special program. The AAMC has received formal inquiries from seven other organizations, and hopes to extend the program to one or more other organizations in the near future.

IMPLEMENTATION OF CAPITATION PROVISIONS OF PUBLIC LAW 94-484

Primary Care Graduate Medical Education

The Health Manpower Act of 1976 requires that there be a specified percentage of all filled G-1 positions in the primary care specialties of family medicine, internal medicine and pediatrics in programs directly sponsored by or affiliated with medical schools. If the aggregate national percentage of primary care filled G-1 positions is thirty-five percent in 1977, forty percent in 1978, and fifty percent in 1979, individual schools do not have to meet these percentages.

When the schools were surveyed this summer, fifty-two percent of the positions in direct and affiliated programs were found to be in primary care. This proportion was achieved even when positions were discounted if the individual occupying a primary care position the previous year was no longer in a primary care program. Unless there is an unanticipated change in the career aspirations of students graduating in 1978 and 1979, it is expected that the proportion of students occupying G-1 positions in primary care will exceed the percentages specified for all three years of the Act.

There may be a Congressional effort to amend the Act to increase the discount by deducting filled positions in the subspecialty training programs of internal medicine and pediatrics from the aggregate of G-1 positions in primary care.

Reserve Positions for U.S. Foreign Medical Students

This highly controversial provision is now in the process of being amended by Congress. What the outcome will be cannot be foretold at this writing. Eight hundred and twenty-eight U.S. citizens have been identified as eligible under the provision which was enacted. These are individuals who were enrolled in a foreign school prior to October 12, 1976, have completed two years of education in that school, and have passed NBME Part I. Amendments in both Houses of Congress are directed toward requiring schools to enroll a proportion of students in advanced study and limiting the categories from which such students may be drawn. For certain, permissible categories will be those 828 students who have been identified under the extant provision, and students from schools which depend upon transferring all or part of their students to other institutions for their clinical education. Excluded categories will certainly be students enrolled in M.D. degree granting schools which normally provide all phases of education to all their matriculants, and students seeking to transfer from other health professional schools such as dentistry. The proposed amendments do not interdict schools utilizing their usual criteria (including academic achievement and place of residence) in making selection decisions.

Whether the amendments will pass the Congress is not certain at this time.

FACULTY DEVELOPMENT PROGRESS REPORT

The Division of Faculty Development has recently completed its third full year of activity. The original goals have remained the primary commitment of this program: (1) To help stimulate faculty interest in educational issues, and to encourage their pursuit of self-improvement activities in this area; (2) To provide an opportunity for faculty to gain a confidential, individual assessment of their competence in the area of education; (3) To provide assistance to faculty in the solution of educational problems; (4) To identify and develop resources for assisting faculty to enlarge their understanding of educational issues, to enhance their competence in educational design and implementation, and to broaden their awareness of options that are available in solving educational problems.

These goals were translated into the following specific activities and events during the past year.

The Self-Assessment Project

As an expression of all four Divisional goals, we are preparing materials and strategies that will provide individual faculty members with an opportunity to secure a confidential self-assessment of their own instructional characteristics. The primary instruments will be the written simulations that were used in the National Survey (see below), supplemented by documents which provide the respondent with: (1) interpretations of the major routings through the simulations, (2) a basis for critiquing their own responses, (3) a general discussion of relevant principles and issues, and (4) a brief list of references. To supplement this self-critique with the more thorough and individualized guidance that can be provided by a suitably prepared educational consultant we have included such preparation for participants in our workshops (see below). To date we have developed preliminary versions of half of the supplementary documents, which are now undergoing field trials at six medical schools. The remaining supplementary documents and their field trials will be completed during the next several months. We anticipate having the self-assessment materials ready for general distribution to interested faculty members in Spring, 1978.

The National Survey of Medical Faculty

This was the middle year of a 3-year project which is seeking answers to the following questions: (1) How have medical faculty members prepared for their teaching responsibilities?; (2) What instructional approaches do medical faculty members characteristically utilize?; (3) In which instructional areas do faculty members have problems?; and (4) In what instructional areas do faculty members want help, if available? During this past year survey instruments were distributed to a stratified-random, verified sample of 2692 full-time U.S. medical school faculty members. Usable responses were received from 71% of this sample. Data compilation and analyses were begun and three preliminary reports of the findings were distributed to the medical

schools. The high return rate warrants confidence in the generalizability to the approximately 28,400 full-time medical faculty members with undergraduate teaching responsibilities. A final report --which summarizes and interprets both the results released so far and those based on further analyses--is currently being prepared for distribution later this year.

Workshops

During the past year we offered our first Workshops on Faculty Development. They were intended for medical school faculty members who have responsibilities in the area of faculty development. The workshops focused mainly on planning, running and evaluating workshops or faculty self-assessment activities. The participants reviewed a set of questions to be answered in designing a workshop and/or a self-assessment activity; received and discussed a set of check-lists which help assure that necessary steps are followed in an appropriate sequence; participated in and discussed exercises which focused on issues which would help enhance their effectiveness as educational consultants; worked on planning a workshop or a self-assessment activity; and exchanged problems and possible solutions among each other. The locations, dates, number of participants and number of medical schools represented at each workshop are summarized below:

Location	Dates	Participants	Institutions
San Francisco, California	11/10/76	42	23
Washington, D.C.	4/11-12/77	41	24
Springfield, Illinois	5/12-13/77	36	18
Aspen, Colorado	7/25-26/77	38	23
		157	72*

Information Sharing

The Division of Faculty Development's responsibility for two publications was discontinued during this past year. Responsibility for the "Curriculum Directory" was transferred to the Division of Educational Measurement and Research. The Executive Council decided to terminate publication of the "AAMC Education News."

*The numbers in this column are not cumulative as some medical schools were represented at more than one workshop.

NEW MCAT PROGRESS REPORT

The New MCAT was administered for the first time in April 1977 to approximately 30,600 examinees. At this time, it is estimated that the number of persons taking the test at the fall administration was about 27,000. Although this represents an increase of approximately 4000 persons over the last year, it should not necessarily be construed as an increase in the applicant pool since there was probably a significant number who deferred taking the test until the new form was available.

Reaction to the test, both from the standpoint of the examinees and from the standpoint of the results obtained from preliminary data analyses has been quite favorable. Though the general response of examinees is that it is a rather fatiguing experience, reports indicate that the test is viewed as interesting and as relevant to its intended purpose.

A major objective of the new examination is to provide more differentiated information about the academic background in the requisite sciences of medical school applicants. In addition, a concerted effort has been made to measure those skills which have been identified as being relevant to success in both the basic and clinical sciences. Accordingly, performance on the test is reported in six different areas, including achievement in biology, chemistry, physics, science problems, skills analysis: reading, and skills analysis: quantitative.

The following observations are based upon preliminary analysis of the data gathered at the spring administration of the New MCAT. With regard to the "technical performance" of the test, the reliability coefficients were found to be in the acceptable range, from .81 to .86, with only the skills analysis: reading falling outside that range, at .76. The indication is that there is a good spread within the distribution of scores in each area of assessment. Further room exists at both extremes of these distributions for upward or downward shifts of group performance.

Scores from all six areas of assessment were intercorrelated to evaluate potential redundancies in the measurements. The highest correlations appear between those tests measuring the same skills, while lower correlations generally are found for those tests requiring the mastery of separate bodies of knowledge. These findings support the conclusion that each score does contribute something new to the candidate's profile, and that serious redundancy does not exist among the data provided.

Since the test did attempt to measure achievement in the requisite premedical sciences, the performance of examinees majoring in those areas was reviewed to obtain an internal measure of the consistency of the results reported. As hypothesized, the biology and biological science majors obtained the highest means in the area of biology, with chemistry majors having the highest scores in the chemistry area, and physics and physical science majors, highest in the physics area. Further consistency was identified in the performance of those majoring in mathematics, statistics, physics and the physical sciences, as those having the highest means on the quantitative subtest. As the literature also would have predicted, humanities majors and social science majors had the highest scores on the skills analysis: reading subtest. Those majoring in physics, physical sciences, and chemistry achieved the highest means reported for the science problems subtest. All of these data support the inference that the test can be used to differentiate varying levels of undergraduate preparation within and between the requisite premedical sciences.

In addition to analyzing last spring's performance, a parallel form of the test was administered to groups of students at several medical schools across the country for the purpose of enriching the interpretive information available for the use of test results in this year's application decisions. These data may suffer from a lack of representativeness and restriction of range, but are useful in suggesting the minimum values that are likely to be found in the more appropriate longitudinal studies addressing such questions. The results of these studies strongly support the value of scores from each area of assessment in accounting for performance both in course work and on the National Boards. Obviously, scores from some parts of the test are more valuable than others in predicting performance in the various courses of medical school. However, the findings do indicate that each score reported is of value in predicting some important component of achievement in the first two years of medical school, and that often two or more areas of assessment bear a strong relationship with that achievement. The significant correlations observed range from the middle .20's to the middle .70's, with the vast majority being concentrated in the upper .30's, .40's, and .50's. Data relating performance on the six areas of assessment to National Board performance were also studied with an available sample of third year students and found to yield consistently significant correlations with each of the 8 measures reported in Part I of the National Boards. These significant relationships were found primarily in the science related areas of assessment on the New MCAT, and ranged from the upper .30's to the lower .50's.

Future research will profitably be directed toward a determination of the most efficient use of New MCAT measures as predictors of important performance criteria, either singly or in combination. These studies must be conducted both nationally and on an institutional basis.

STATUS OF TRAINEESHIP AND SCHOLARSHIP TAXATION

In August a formal ruling by the Internal Revenue Service (IRS) held that National Research Service Awards, National Health Service Corps Public Health Service and U.S. Armed Forces scholarships are fully taxable to the individual receiving them retroactive to January 1, 1977. The Association had earlier argued with the IRS in vain to affect this formal ruling. Therefore, during August the Association submitted statements to the Congress urging it to reverse current policy. Two lines of activity are being pursued.

Armed Forces, PHS and National Health Service Corps Scholarships

National Health Service Corps Scholarships provide health professions personnel who will serve in health manpower shortage areas in exchange for scholarships for these individuals while in health professions schools. Students first receiving NHSC scholarships before January 1, 1977 received them tax free, but students receiving them in 1977 and subsequent years will be fully taxed. Our efforts to reverse the current tax policy finally seem to be making some impact. On September 20 a new bill (HR.9251) with 19 co-sponsors was introduced into the House and, on September 22, the House Ways and Means Committee approved this bill including provisions to make the NHSC and Armed Forces Scholarships non-taxable. The bill has been reported out of Committee under a suspension of the rules request, so that the House may vote on the bill without delay. If passed by the House, the bill must be considered by the Senate Finance Committee, where Senators Robert Dole (R-KS), Gaylord Nelson (D-WI), and Herman Talmadge (D-GA) are known to be supportive of tax relief for these medical scholarships.

National Research Service Awards

For many years the first $3,600 of research training awards - both direct fellowships and training grants - have been excludable as income for tax purposes. The Association has been working through members of the Senate Finance Committee to obtain an amendment to the tax correction tax of 1977 (HR.6715) which would classify National Research Service Awards as tax-exempt scholarship awards under Section 117 of the Internal Revenue Code.

STATUS OF LCME RECOGNITION BY U.S. OFFICE OF EDUCATION

The Liaison Committee on Medical Education (LCME) has as a joint enterprise of the AMA and AAMC accredited U.S. medical schools since 1942. In the late sixties, the LCME was recognized by the U.S. Office of Education (USOE). This recognition is necessary so that medical schools may receive grants when a provision of law requires that recipient schools must be accredited by an accrediting agency recognized by the U.S. Government.

In November 1976 the Federal Trade Commission wrote to the U.S. Office of Education raising questions regarding whether the LCME should be recognized because it was alleged that the involvement of the AMA in the LCME constituted a potential conflict of interest. Subsequently, a regularly scheduled hearing for review of the Liaison Committee's renewal of recognition by the USOE was delayed for several months so that the LCME could prepare a response. A hearing was held in March 1977 and subsequently the USOE extended recognition to LCME for two instead of the standard four years.

The USOE has communicated to the LCME a set of requirements directed toward making the LCME more independent of its sponsoring organizations (AAMC and AMA). These are as follows.

1) That the AMA and the AAMC authorize the LCME to exercise final authority with respect to determining the accreditation status of all schools of medicine, including decisions regarding probation and disaccreditation.

This authorization does not contemplate revision of the long-standing procedure for prior review of the site visit reports by the members of the AAMC Executive Council, the AMA Council on Medical Education and its Advisory Committee on Undergraduate Medical Education, and the submission by these members of non-binding advisory comments on the report and the recommendations of the survey team.

2) That the AMA and the AAMC authorize the LCME to exercise final authority to adopt its own policies and operating procedures.

This authorization contemplates only the assignment to the LCME of the locus of the final authority for the adoption of the policies and procedures. It is proposed to retain the existing procedures for legislative due process involving the submission of all major policy changes or questions to the various communities of interest for review and comment prior to their resolution or the amendment of policy or procedures documents by the LCME. Those who would be requested to comment would be the parent associations of the LCME, the deans and faculty members, student organizations and others.

3) As required by the USOE, the LCME has reviewed its anticipated operating expenditures for 1977-1978 and presents a budget estimate to its fiscal sponsors for their approval.

This change in practice contemplates the continuing financial support of the LCME by the AMA and the AAMC (to which USOE raises no objection) according to the long established practices which include an annual post-year audit of the LCME accounts of the fiscal sponsors and the allocation of the direct costs of the operations of the LCME to each parent in equal shares.

4) That the current sponsors of the LCME, i.e., the AAMC and the AMA, endeavor to clarify the relationship between the Liaison Committee on Medical Education and the Coordinating Council on Medical Education.

Recognition of the Liaison Committee on Medical Education was achieved on the basis that accreditation decisions of the LCME did not require the approval of the Coordinating Council on Medical Education, and that other relationships between CCME and LCME were still under consideration. The USOE staff informed the LCME staff that were the currently defined relationship to be altered, the continued recognition of the LCME would have to be reconsidered by the USOE. The LCME is required to report any change to the USOE.

5) That the LCME be authorized to establish formal criteria for the appointment of its members.

The USOE staff informed the LCME staff that in general the present AAMC selection procedure was satisfactory. In contrast, the USOE staff indicated that nominations to the LCME by the AMA should arise only from a focus devoted solely to educational matters, such as the Council on Medical Education. Membership alone in an organization such as the AMA is not considered to be a suitable criterion for LCME appointment. In addition, members should be appointed to staggered terms of suitable duration such as three years, for the purpose of continuity.

The Executive Council of the Association found these requirements reasonable if it is made clear that the sponsoring organizations will retain the authority to approve the standards against which medical schools are judged. These standards are set forth in the documents, Functions and Structure of a Medical School and Guidelines for Functions and Structure of a Medical School. As yet, the LCME has not officially responded to the USOE request.

THE OLDER AMERICANS ACT OF 1975 AND AGE DISCRIMINATION

The 1975 Older Americans Act will be implemented in 1979. The Act is directed toward ensuring that our enlarging older population is provided access to services and job opportunities. One provision of the Act is that there must not be unreasonable discrimination because of age in admission to educational institutions and their programs which receive federal funds. During 1977, hearings were held by the Civil Rights Commission, chaired by Dr. Arthur A. Fleming. The Commission's purpose was to explore the extent of age discrimination and how implementation through regulations should be pursued by federal agencies. A report by the Commission is due on November 30th.

A particular point of interest of the Commission is whether there is unreasonable age discrimination in admission to higher education programs, especially medicine. Data from the AAMC's Medical Student Information System indicates that chronological age per se is not solely used to make acceptance or rejection decisions. It is clear, however, that the acceptance rates for age groups beyond 23 years is less than for the immediate college graduating population. The reasons why older applicants fare less well in the admissions competition are multiple, and most are not quantifiable. Many do not present academic credentials which are equivalent to younger students. Older applicants come from a broader spectrum of undergraduate college majors and career evolutions. Motivational factors which cause them to decide to seek a career in medicine are more diverse and, because of their previous work experience, more evident to scrutiny. The Association in its testimony before the Commission held that statements by medical schools discouraging older applicants are not made on the basis of age discrimination; but are made to inform such applicants that in the competition for admission, older applicants, who must compete with each year's new crop of college graduates, do not fare as well.

A reason often given for not admitting older applicants is that medical school faculties have a social responsibility to select those who, upon completion of their education, will be able to serve society for a sufficiently long period to justify their having utilized the considerable and scarce resources needed to educate them. The right of faculties to assume that authority in making individual admission decisions is a question which the Commission is debating. How this issue is resolved will be important. However, whether medical schools' faculties are or are not permitted some latitude in taking age versus length of potential service into account, in the future more explicit statements on selection factors will be necessary. Refusing to consider an applicant solely because of chronological age will be challenged and will be difficult to justify.

COUNCIL OF DEANS/COUNCIL OF ACADEMIC SOCIETIES/
COUNCIL OF TEACHING HOSPITALS

TUESDAY, NOVEMBER 8

Ballroom Center

CHALLENGES IN GRADUATE MEDICAL EDUCATION

SESSION I

TRANSITION BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

Moderator: Julius R. Krevans, M.D.

1:30 p.m. The Transition to Graduate Medical Education - A Student's Point of View
Thomas A. Rado, M.D., Ph.D.

The Readiness of New M.D. Graduates to Enter Their GME-1 Year
Barbara Korsch, M.D.

The Search for a Broad First Year
William Hamilton, M.D.

SESSION II

QUALITY OF GRADUATE MEDICAL EDUCATION

Moderator: A. Jay Bollet, M.D.

2:45 p.m. The Evaluation of Residents' Performance
John A. Benson, Jr., M.D.

Supervisory Relationships in Graduate Medical Education
William P. Homan, M.D.

The Program Director's Responsibility
Thomas K. Oliver, Jr., M.D.

4:00 p.m. Adjourn

COUNCIL OF DEANS/COUNCIL OF ACADEMIC SOCIETIES/
COUNCIL OF TEACHING HOSPITALS

WEDNESDAY, NOVEMBER 9

Ballroom Center

CHALLENGES IN GRADUATE MEDICAL EDUCATION

SESSION III

INFLUENCING SPECIALTY DISTRIBUTION THROUGH GRADUATE MEDICAL EDUCATION

Moderator: David D. Thompson, M.D.

9:00 a.m. The Coordinating Council on Medical Education Should Participate with the Federal Government to Regulate Opportunities for Specialty Training
John C. Beck, M.D.

The Private Sector Should Avoid Participating with the Federal Government
C. Rollins Hanlon, M.D.

SESSION IV

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION - THE McGAW MEDICAL CENTER OF NORTHWESTERN UNIVERSITY EXPERIENCE

Moderator: Robert L. Van Citters, M.D.

10:45 a.m. The Concept and its Development
James Eckenhoff, M.D.

How it Operates
Jacob Suker, M.D.

How it Affects the Program Director
Henry L. Nadler, M.D.

Its Impact on the Teaching Hospital
David L. Everhart

12:30 p.m. Adjourn

Revised Ballot

aamc association of american medical colleges

BALLOT

COUNCIL OF ACADEMIC SOCIETIES

1977-78

ADMINISTRATIVE BOARD POSITIONS

CHAIRMAN-ELECT

Vote For One:

33 FREEDMAN, Daniel X., M.D.

American Association of Chairmen of Departments of Psychiatry

FREEDMAN, DANIEL X, b. Lafayette, Ind, Aug. 17, 21; m. 45. PSYCHIATRY. B.A, Harvard, 47; M.D, Yale, 51. Intern pediat, sch. med, Yale, 52-55, res. psychiat, 55, instr, 55-58, chief res, 55-56, asst. prof, 58-61, assoc. prof, 61-64, prof, 64-66, dir. psychopharmacol. unit, 58-66; PROF. PSYCHIAT. & CHMN. DEPT, UNIV. CHICAGO, 66- Attend. psychiatrist, Vet. Admin. Hosp, West Haven, Conn, 55-66; assoc. psychiatrist, Grace-New Haven Community Hosp, 55-66; consult, juvenile courts, 55-57; Fairfield State Hosp, 58-66, U.S. Dept. Army, 65-67; career investr, Nat. Inst. Ment. Health, 57-66, consult. psychopharmacol. study sect, 60-65, mem. drug eval. comt, 65-67, res. scientist, develop. review comt, 70-; mem. comt. on brain sci, Nat. Res. Coun, 70-; chief ed, Archives Gen. Psychiat. U.S.A, 42-46. Am. Psychiat. Asn; Am. Soc. Pharmacol. & Exp. Therapeut; Am. Col. Neuropsychopharmacol; Soc. Psychophysiol. Res; Am. Med. Asn; Group Advan. Psychiat; Int. Brain Res. Orgn; Int. Col. Neuropsychopharmacol. Psychopharmacology; psychoanalytic, neurophysiologic and social investigation in schizophrenia; central nervous system determinants of allergy; drugs, brain function and behavior; methodology of drug studies. Address: Dept. of Psychiatry, University of Chicago, 950 E. 59th St, Chicago, IL 60637.

✓ 36 OLIVER, Thomas K., Jr., M.D.

Association of Medical School Pediatric Department Chairmen

OLIVER, THOMAS K, JR, b. Hobart Mills, Calif, Dec. 21, 25; m. 49; c. 2. PEDIATRICS. California, Berkeley, 43-45; M.D, Harvard Med. Sch, 49. Instr. pediat, med. col, Cornell, 53-55; asst. prof, Ohio State, 55-60, assoc. prof, 60-63; PEDIAT, Univ. Wash, 63-65, prof, 65-70; PROF. & CHMN. DEPT, SCH. MED. UNIV. PITTSBURGH, 70-; MED. DIR, CHILDREN'S HOSP. PITTSBURGH, 70- Spec. fel. neonatal physiol, Karolinska Inst, Sweden, 60-61. Med.C, 51-53, 1st Lt. Soc. Pediat. Res; Am. Pediat. Soc; Am. Acad. Pediat. Neonatal biology; pulmonary physiology in childhood; acid-base physiology. Address: Dept. of Pediatrics, Children's Hospital of Pittsburgh, 125 DeSoto St, Pittsburgh, PA 15213.

ADMINISTRATIVE BOARD, CLINICAL SCIENCES

Vote For One: (To be elected for a term of two years to complete the unexpired term of Dr. Eugene Braunwald)

27

BRASEL, Jo Anne, M.D.

Endocrine Society

BRASEL Jo Anne Cert Pd 65. b 34 Salem Ill. MD Colo 59. Intern Pd 59-60 Res Pd 60-62 (NY Hosp-Cornell Med Center) Fell Pd Endocrin (Johns Hop) 62-65. Asst Prof Pd (Johns Hop) 65-68 Asst Prof Pd 69-71 Assoc Prof Pd 71-72 (both at Cornell) Assoc Prof Pd & Chief Div Growth & Devel Inst Human Nutrition (Colum P&S) 72—. AFCR-EndocrinS-Soc Developmental Biology-Am Soc Clin Nutrition-Am Inst Nutrition-SPR-Alpha Omega Alpha. Colum P&S Black Bldg 217 630 W 168th St New York NY 10032 Tel (212) 579-3984

✓ 38

WILSON, Frank C., Jr., M.D.

American Academy of Orthopaedic Surgeons

WILSON, FRANK C(RANE), b. Rome, Ga, Dec. 29, 29; m. 51; c. 3. MEDICINE, ORTHOPEDIC SURGERY. A.B, Vanderbilt, 50; M.D, Med. Col. Ga, 54. Instr. ORTHOP. SURG, Columbia, 63; SCH. MED, UNIV. N.C, CHAPEL HILL, 64-65, asst. prof, 65-68, assoc. prof, 68-71, PROF, 71- Markle scholar, 66- Chief div. orthop. surg, N.C. Mem. Hosp, 67. Consult, Watts Hosp, Durham, N.C, 65- Dipl, Am. Bd. Orthop. Surg, 67. U.S.N, 56-58, Lt. Comdr. AAAS; Am. Col. Surg; Am. Rheumatism Asn. Trauma; infections of bones and joints; rheumatoid arthritis. Address: Division of Orthopedic Surgery, North Carolina Memorial Hospital, Chapel Hill, NC 27514.

ADMINISTRATIVE BOARD, BASIC SCIENCES

Vote For Four: (One to be elected for a term of one year to complete the unexpired term of Dr. Leslie Webster)

✓ 35

BISHOP, F. Marian, Ph.D.

Society of Teachers of Family Medicine

BISHOP, F. Marion, B.S., U. of Missouri; Ph.D., Wash.U.St.Louis; U. of Missouri, 63-70; U. of Maryland-Frankfurt, Germany; Visiting Scientist-Health Services & Mental Health/DHEW, 71-72; Consultant-Missouri Council on Smoking & Health; R.L.D.S. World Church's Family Ministry Advisory Community; Professor of Family Practice & Community Health, Psychiatry & Behavioral Sciences, U. of Oklahoma, 72-74; Professor of Community Health, U. of Alabama, Huntsville, 74-. Address: School of Primary Medical Care, U. of Alabama, Huntsville, AL 35807.

✓ 30

BROWN, David M., M.D.

Academy of Clinical Laboratory Physicians and Scientists

BROWN David M Cert Pd 66 (PdNeph) 74. b 35 Chgo. MD Ill 60. Intern (Ill Research & Ed Hosps) 60-61 Res 61-63 Prof Dept Lab Med & Pd & Dir Clin Lab (both at U Minn Hosps) Fell Endocrin & Metabolism (U Minn) 63-65. Capt MC USAF 65-67. EndocrinS-SPR-ASCP-ASN-CSCR-Or Research Soc-Am Physiol Soc-Lawson Wilkins Pd Endocrin Soc-Pd Nephrology Soc. U Minn Hosp Minneapolis MN 55455 Tel (612) 373-8114

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DEVLIN, Thomas M., Ph.D.

Association of Medical School Departments of Biochemistry

DEVLIN, THOMAS M(cKEOWN), b. Philadelphia, Pa, June 29, 29; m. 53; c. 2. BIOCHEMISTRY. B.A, Pennsylvania, 53; Nat. Sci. Found. fel, Hopkins, 54-55, U.S. Pub. Health Serv. fel, 55-57, Ph.D.(physiol. chem), 57. Asst. org. chem, Sharples Corp, Pa, 47-49; asst. biophysics, Johnson Found, Pennsylvania, 49-53; res. assoc. enzyme chem, Merck Inst, 57-61, sect. head, biol. cancer res, 61-66, dir. enzymol, 66-67; PROF. & CHMN. DEPT. BIOL. CHEM, HAHNEMANN MED. COL. & HOSP, 67- Vis. res. scientist, Brussels, 64-65. AAAS; Am. Soc. Biol. Chemists; Am. Asn. Cancer Res; Biochem. Soc; Am. Soc. Cell Biol; Am. Chem. Soc; N.Y. Acad. Sci. Enzyme chemistry; oxidative phosphorylation and electron transport; mitochondrial physiology and biogenesis; biochemical control mechanisms; intermediary metabolism of malignant tissues; cancer chemotherapy; spectrophotometric techniques. Address: Dept. of Biological Chemistry, Hahnemann Medical College, 235 N. 15th St, Philadelphia, PA 19102.

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JONES, Mary Ellen, Ph.D.

American Society of Biological Chemists

JONES, MARY ELLEN, b. La Grange, Ill. Dec. 25, 22; c. 2. BIOCHEMISTRY. B.S. Chicago, 44; U.S. Pub. Health Serv. fel, Yale, 50-51, Ph.D, 51. Res. chemist, Armour & Co, 42-48; Atomic Energy Cmn. fel, biochem. res. lab, Mass. Gen. Hosp, 51-53, Am. Cancer Soc. fel, 53-55, assoc. biochemist, 55-57; asst. prof. biochem, Brandeis Univ, 57-60, assoc. prof, 60-66; Univ. N.C, Chapel Hill, 66-68, prof, 68-71, partic. assoc. prof. zool, 67-69, PROF, 69-71; BIOCHEM, UNIV. SOUTH. CALIF, 71- Am. Cancer Soc. scholar, 57-62, dir. dent. training grant, 62-66; mem. biochem. study sect, Nat. Insts. Health, 71- AAAS; Am. Chem. Soc; Am. Soc. Biol. Chem; N.Y. Acad. Sci; Am. Cancer Soc. Enzymology, biosynthetic and transfer reactions, metabolic regulation of enzymes; carbamyl phosphate, acetyl-coenzyme A, cathespsin C and transamidation reactions. Address: Dept. of Biochemistry, University of Southern California School of Medicine, 2025 Zonal Ave. Los Angeles, CA 90033.

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LIEBERMAN, Seymour, Ph.D.

Endocrine Society

LIEBERMAN, SEYMOUR, b. N.Y.C, Dec. 1, 16; m. 44; c. 1. BIOCHEMISTRY. A.B, Brooklyn Col, 36; M.S, Illinois, 37; Ph.D.(chem), Stanford, 41. Chemist, Schering Corp, 38-39; Rockefeller Found. asst, Stanford, 39-41; spec. res. assoc, Harvard, 41-45; assoc, Sloan-Kettering Inst, 45-50; asst. prof. BIOCHEM, COL. PHYSICIANS & SURG, COLUMBIA UNIV, 50-52, assoc. prof, 52-62, PROF, 62- Traveling fel. from Mem. Hosp, New York to Basel, Switz, 46-47; mem. panel steroids, comt. on growth, Nat. Res. Coun, 46-50, panel endocrinol, 55-56; endocrinol. study sect, Nat. Insts. Health, 58-63, mem, Insts, 59-65, chmn, 63-65, gen. clin. res. ctrs. comn, 67-70; med. adv. comt, Pop. Coun, 61-; assoc. ed, J. Clin. Endocrinol. & Metab, 63-67. AAAS; Am. Chem. Soc; Am. Soc. Biol. Chem; Endocrine Soc.(Ciba Award, 52, v.pres, 67, Koch Award, 70). Steroid chemistry and biochemistry; metabolism of hormones; steroid hormone-protein conjugates. Address: College of Physicians & Surgeons, Columbia University, 630 W. 168th St, New York, NY 10032.

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MANDEL, H. George, Ph.D.

Association for Medical School Pharmacology

MANDEL, H(AROLD) GEORGE, b. Berlin, Ger, June 6, 24; nat; m. 53; c. 2. PHARMACOLOGY. B.S, Yale, 44, Ph.D.(org. chem), 49. Asst. & lab. instr. chem, Yale, 42-44, lab. instr. org. chem, 47-49; res. assoc. PHARMACOL, SCH. MED, GEORGE WASH. UNIV, 49-50, asst. res. prof, 50-52, assoc. prof, 52-58, PROF, 58-, CHMN. DEPT, 60- Adv. Commonwealth Fund fel, Molteno Inst, Eng, 56; Pasteur Inst, France, 57; lectr. U.S. Naval Dent. Sch, 59-61, 71-; Washington Hosp. Ctr, 60-66; Commonwealth Fund sabbatical leave, Univ. Auckland, N.Z. & Univ. Med. Sci, Thailand, 64. Consult. Fed. Aviation Agency, 61-62. Mem. biochem. comt, Cancer Chemother. Nat. Serv. Ctr, 58-61; med. adv. comt, Therapeut. Res. Found, Inc, 62-; pharmacol. & exp. therapeut. B study sect, U.S. Pub. Health Serv, 63-68; comt. probs. drug safety, Nat. Acad. Sci-Nat. Res. Coun, 65-71, mem. drug metab. workshop progs, N.Y. Univ, 66, George Wash. Univ, 67 & Univ. Calif, 68; mem. cancer chemother. comt, Int. Union Against Cancer, 66. Am. Cancer Soc. Eleanor Roosevelt Int. Fel, Chester Beatty Res. Inst, London, 70-71; mem. cancer res. training comt, Nat. Cancer Inst, 70; res. comt, Children's Hosp, Wash. D.C, 69-; sci. adv. comt, Registry Tissue Reactions to Drugs, 70- Int. Pharmacol. Cong. travel award, Prague, 63. U.S.A. 44-46. AAAS; Am. Soc. Pharmacol. & Exp. Therapeut.(Abel award, 58, secy, 61-63, pres. elect, 72-73); Am. Chem. Soc; Am. Soc. Biol. Chem; Am. Asn. Cancer Res; Asn. Am. Med. Cols; Am. Soc. Microbiol. Drug metabolism; mechanism of drug action; biochemistry of nucleic acids of normal and malignant tissue; antimetabolites and other anti-cancer drugs; action of drugs on microorganisms. Address: Dept. of Pharmacology, George Washington University School of Medicine, Washington, DC 20005.

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PRESTON, James B., M.D.

Association of Chairmen of Departments of Physiology

PRESTON, JAMES B(ENSON), b. Nelsonville, Ohio, Feb. 4, 26; m. 47; c. 3. PHYSIOLOGY. Ohio Wesleyan, 44-45, 47-48; M.D, Cincinnati, 52. Intern, Res. & Ed. Hosps. & instr. pharmacol, col. med, Illinois, 52-54; instr. PHYSIOL, STATE UNIV. N.Y. UPSTATE MED. CTR, 54-56, asst. prof, 56-60, PROF. & CHMN. DEPT, 60- U.S. Pub. Health Serv. sr. res. fel, 58-60; mem. physiol. training comt, Nat. Inst. Gen. Med. Sci, 71-; physiol. test comt, Nat. Bd. Med. Exam, 72- Med.C, U.S.A, 45-47. AAAS; Soc. Gen. Physiol; Am. Physiol. Soc; Am. Soc. Zool; Soc. Neurosci. Physiology of the nervous system. Address: Dept. of Physiology, State University of New York Upstate Medical Center at Syracuse, Syracuse, NY 13210.

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YOUNG, Frank E., M.D., Ph.D.

Association of Medical School School Microbiology Chairmen

YOUNG, FRANK E, b. Mineola, N.Y, Sept. 1, 31; m. 56; c. 5. PATHOLOGY, MICROBIOLOGY. Union Col, 49-52; M.D, State Univ. N.Y, 56; Ph.D.(microbiol), Western Reserve, 62. Intern path, Univ. Hosps, Cleveland, Ohio, 56-57, res, 57-60; instr, Western Reserve, 62, asst. prof, 62-65; assoc. mem, depts. microbiol. & exp. path, Scripps Clin. & Res. Found, 65-68, mem, 68-70; PROF. MICROBIOL, PATH, RADIATION BIOL. & BIOPHYS. & CHMN. DEPT. MICROBIOL, SCH. MED. & DENT, UNIV. ROCHESTER, 70- Am. Cancer Soc. res. grant & faculty res. assoc, 62-; Nat. Insts. Health res. grant, 65, training grant, 70-; assoc. prof, Univ. Calif, San Diego, 67-70; dir. clin. microbiol. labs, Strong Mem. Hosp, 70-; dir, Health Dept. Labs, Monroe County, 70-; Nat. Sci. Found. Res. grant, 70- AAAS; Am. Soc. Microbiol; Am. Soc. Biol. Chem; Am. Soc. Exp. Path; Am. Asn. Path. & Bact. Mechanism of deoxyribonucleic and mediated transformation of bacterial and animal cells; regulation of bacterial cell surface; effect of heavy metals on DNA. Address: Dept. of Microbiology, School of Medicine & Dentistry, University of Rochester, Rochester, NY 14642.