FOCUS ON MENTAL HEALTH OF THE AGING

■ Public awareness of the needlessly high risk of mental disorder among older Americans has emerged gradually in recent years. Acknowledgement of the psychosocial toll of growing old has stimulated Federal legislative and administrative activities directed toward determining and meeting the needs of the aged.

Among these activities was the establishment in August 1975 of the Center for Studies of Mental Health of the Aging in the National Institute of Mental Health (NIMH). The Center was set up to centralize diverse efforts in research, development and delivery of services, and professional training that have long been priorities of the Institute. In its first year, devoted primarily to planning, the Center has proved its usefulness in coordinating activities concerned with the mental health of the elderly. The Center's staff has conferred not only with other components of the Department of Health, Education, and Welfare (DHEW), but also with other Federal and local government agencies and with private organizations and consumers. For example, staff members have discussed with representatives of the Department of Housing and Urban Development strategies for developing innovative plans for housing homeless older persons.

Concurrent with the establishment of the Center, enactment of the 1975 amendments to the Community Mental Health Centers Act (P.L. 94–63) signified strong congressional interest in the plight of the elderly. In a virtual overhaul of the original CMHC law (P.L. 88–164), the new legislation requires that comprehensive community mental health centers provide a full range of services for the elderly, including diagnostic, treatment, liaison, and followup services.

The CHMC amendments also directed the formation, through DHEW, of the Committee on Mental Health and Illness of the Elderly. Formally convened in September 1976, the Committee is conducting a year-long analysis of future needs for mental health programs to serve the aging. In addition, the Committee will make recommendations concerning the care of elderly persons residing in or recently discharged from mental institutions and will implement strategies developed by the 1971 White House Conference on Aging.

Historical Overview

Concern with the problems of the aged was in evidence in NIMH's first appropriation in 1948, which provided funding of a research grant for a study of tolerance to environmental stress by older persons. Over the succeeding years, NIMH scientists and grantees have studied subjects ranging from the biochemistry of organic brain syndromes to the design and development of long-term care facilities. In the early 1950s, NIMH helped establish the Center for the Study of Aging and Human Development at Duke University and supported a now classic study by the center on the relationship of physiological, psychological, and social factors to the aging process. Research programs were also established with NIMH help at the University of Chicago, through its Committee on Human Development, and at the Langley Porter Neuropsychiatric Institute in San Francisco.

A section on aging was established as part of the NIMH intramural research program in 1953 to focus on the aging process and mental illness as it is related to aging. When the National Institute of Child Health and Human Development was formed in 1963, the bulk of the NIMH projects on aging were transferred to the new Institute and the intramural section was phased out.

In 1966, a section on aging was reestablished in NIMH, this time to coordinate research, training, and service activities in the extramural support programs. The Center for Studies of Mental Health of the Aging will expand the activities of this section. Its current responsibilities include stimulating professional interest in research on aging, assisting prospective grantees in the development of research applications, and advising NIMH components about proposed projects that are relevant to mental health and aging.

Gene D. Cohen, MD, the geriatric psychiatrist appointed to head the program, views its elevation from a section to a center as particularly significant in the context of related Federal activities, including creation of the National Institute on Aging (NIA). He anticipates that the Center, with its larger staff and greater organizational visibility, will take a more active role in coordinating a program on aging. He believes that eventually the Center will have funds to support research grants directly instead of merely overseeing studies that are funded by other NIMH components.

New Roles

In a recent interview Cohen said: "In response to the CMHC mandate for the elderly, we are currently identifying 'model' service programs or places where there are interesting components of an overall program for the elderly. We plan to write up descriptions of the more striking programs, make them available to centers across the country, and let them examine them for relevancy to local needs. Similarly, we are looking for innovative training programs that focus on community mental health center services. These aims fit into the broad area of technical assistance, a major new role we are trying to develop." Initially, the

technical assistance effort will be directed toward administrators in the 10 DHEW Regional Offices and the staff of individual community mental health centers, Cohen indicated.

Three workshops—one each on research, training, and services—were held during the Center's first year. Approximately 60 professionals from Federal and local government agencies and private organizations participated. Cohen has described the workshops as "intensive phases" in the overall planning efforts, and the Center plans to publish the proceedings as part of a roundup of the activities of the Center's first year.

The Center's staff are seeking to involve agencies and individuals working in all programs directed toward elderly persons, although at times the link to mental health may be indirect. In announcing establishment of the Center in 1975, NIMH Director Bertram S. Brown, MD, expressed concern that the mental health needs of the noninstitutionalized elderly often receive insufficient attention.

"Our program knowledge today focuses on patients who are in hospitals or nursing home," Brown said, "but only 20 percent of the over-65 population require institutionalization at some time, and only 5 percent are actually in institutions at a given time."

Brown urged increased attention to the 95 percent of the elderly who are not in institutions, pointing out that a wide range of services is needed by those residing in their own homes, with relatives, or in senior citizen communities.

Cohen believes that the diversity of the needs of the elderly underscores the importance of participation in NIMH's planning process by such agencies as the National Institute on Aging, the Administration on Aging, and DHEW components dealing with long-term care.

In light of the traditional research role of the National Institute of Mental Health and the mandate for services in the community mental health center legislation, Cohen noted that training issues warrant special attention by the Center. These issues range from identifying gaps in service delivery capabilities, to defining the types of workers best qualified to fill them, and to recruiting new talent to the field.

Cohen indicated that many factors, such as research funds and adequate service settings, are needed to motivate individuals to enter a field. "But already," said Cohen, "we are seeing increased activity among the professional associations. I think we are seeing a reevaluation in all the mental health disciplines regarding the extent to which the aging area should be featured in curriculums."

Secretary's Committee

In addition to providing a solid groundwork for future Center programs, Cohen said that the results of analysis and planning to date have been useful to the work of the Committee on Mental Health and Illness of the Elderly set up to advise the Secretary of HEW. This Committee, whose roots lie in a recommendation of the 1971 White House Conference on Aging to establish a Presidential Commission on Mental Health and Aging, promises to be of help in coordinating the program goals of its three funding sponsors—the National Institute of Mental Health, the National Institute on Aging, and the Administration on Aging—as well as those of other agencies and organizations.

The year-long study and subsequent report by the Committee to the Secretary is expected to go beyond a strict consideration of problems of mental illness among the elderly, according to discussions at the first meeting in September 1976. Chairman Eric Pfeiffer, MD, noted that the mandate is to study the mental health needs of the entire older population. It is important, Pfeiffer said, that the Committee report reflect broad assessment of the impact of public policy and of all human service systems on mental health status.

Brown told the Committee members that a central task would be to delineate the mental health needs of the elderly in specific terms and provide definitive, noncompromising recommendations to the Secretary.

"I consider it vitally important that we . . . assure continuing productive relationships among the many organizational entities working in the field of aging," Brown said. "The fact remains that a person's needs are whole, even though many of the programs devised to serve them are autonomous. Our professional responsibility is to accommodate the needs."

Additional information about the Center for Studies of Mental Health of the Aging is available from Gene D. Cohen, MD, Chief, Rm. 18–95, 5600 Fishers Lane, Rockville, Md. 20857. Reports of the Committee on Mental Health and Illness of the Elderly, as they become available, may be obtained from Carole B. Allan, PhD., Executive Secretary, at the same address.

U.S. MEDICAL SCHOOLS ENROLL RECORD NUMBERS

■ A total of 57,236 medical students were enrolled in 116 medical schools across the country in the fall of 1976, including 15,349 first-year students—a record number, according to the American Medical Association.

The nation's medical school enrollments, however, are leveling off, at least temporarily, the AMA reported. Total enrollment for the 1976 school year was about 9.7 percent greater than the previous year's. The first-year enrollment was about 9.4 percent greater than the first-year enrollment in 1975. The fall first-year enrollment for 1976 was 24 percent greater, and the total enrollment nearly 29 percent greater, than 5 years ago.

Two new medical schools, Wright State University College of Medicine, Dayton, Ohio, and the University of Health Sciences of the Uniformed Services, Bethesda, Md., accepted their charter classes in the fall of 1976.

Women accounted for 20.4 percent of the total enrollment in medical schools in the 1976 school year, about the same percentage as in 1975. Minority students represented 8.2 percent of the total enrollment and 9.3 percent of the freshman class, about the same as in 1975.

These preliminary enrollment figures were gathered in the annual survey of medical schools conducted jointly by the American Medical Association and the Association of American Medical Colleges.

HRA Sponsors Conferences on Energy

■ A series of eight conferences is being conducted by the Health Resources Administration in major regions of the country to discuss the effect of diminishing energy resources on health facilities. Under the title "Energy Management in Health Institutions," three have already been held in Houston, Tex., Atlanta, Ga., and Washington, D.C. Future conferences are scheduled in 1977 at the following locations:

Feb. 28–Mar. 2
Denver, Colo., Cosmopolitan Hotel
Mar. 14–16
Seattle, Wash., Olympic Hotel
Mar. 28–30
San Diego, Calif., U.S. Grant Hotel
Apr. 18–20
Hartford, Conn., Hartford Hilton
May 2–4
Chicago, Ill., Sheraton Chicago

The energy conference series is being cosponsored by the American Hospital Association, American Health Care Association, Blue Cross Association, Federation of American Hospitals, and the Veterans Administration. Cooperating organizations include the Department of Commerce, Energy Research and Development Agency, Federal Energy Administration, and health professional associations.

Lasting 2½ days each, the meetings are providing staff of major health institutions with an understanding of the causes of deteriorating energy reresources in the world. Health and energy authorities are describing to the conferees the nature and scope of the difficulties that energy shortages may soon impose on health services delivery, as well as the energy conservation and other measures that should be undertaken by health facilities. The sponsoring organizations are seeking to motivate health organizations to establish energy conservation programs in health institutions and set up State level and other forums to identify the climatic, regulatory, and energy alternatives and other constraints within which specific energy use control programs must be conducted. The outlook for all traditional energy sources (natural gas, oil, and coal) is for continually rising prices in the foreseeable future. Energy is considered the fastest rising cost in hospital operating accounts, and future increases will have increasingly adverse effects on the cost of delivering health services and the accessibility to care.

According to Burt Kline, director of the Energy Action Staff of the Health Resources Administration, the health sector has been unnecessarily tardy in recognizing the energy problem as an immediate threat to the continued development of high quality care, containment of care costs, and maintenance of accessibility of services. Agriculture, industry, and education are economic sectors that recognized the importance of deteriorating energy resources to their continued effectiveness earlier and began intensive development of energy conservation programs more than a year ago. "Time is short," he said, "and the health sector will have to proceed quickly and effectively if it intends to adequately prepare itself for troublesome times which lie before us."

For further information about these conferences, contact Energy Action Staff, Parklawn Building, Rm. 10A-41, 5600 Fishers Lane, Rockville, Md. 20857, telephone (301) 443-5014.

Conference of the Canadian Foundation on Alcohol and Drug Dependence

■ The Alcoholism Foundation of Manitoba will host the 12th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, July 10–15, 1977, in Winnipeg, Manitoba, Canada.

Major concerns of the conferees will be to examine (*a*) future trends in the chemical dependence field in Canada and (*b*) the influence of the media as it affects substance use and abuse in Canadian society.

For further information and applications write Conference Manager, FUTURACTION '77, The Alcoholism Foundation of Manitoba, 1580 Dublin Ave., Winnipeg, Manitoba R3E OL4.

New Noise Abatement Policy Announced by OSHA

■ Future agreements with employees and employer associations to abate noise exposures on the job will be on a plant-by-plant basis, Dr. Morton Corn, Assistant Secretary of Labor for the Occupational Safety and Health Administration, has announced. Thus, there will be no new negotiation of industrywide agreements.

"Since these agreements lacked specificity," Corn explained, "they have provided neither employers nor OSHA with a yardstick to measure the adequacy of the steps taken or to be taken to comply with noise rules designed to protect workers' hearing."

OSHA has had noise abatement agreements with two industry associations (Western Wood Products Association and the National Concrete Masonry Association) and with the American Can Company and several other employers on a companywide basis.

Corn pointed out that any future agreement will have to be preceded by an inspection of the plant or plants proposed as candidates to be part of the agreement. The inspections are to enable OSHA staff to determine what noise hazards exist and what abatement measures can feasibly be taken to reduce or eliminate the hazards.

OSHA compliance officers are required by law to issue citations when violations of the noise standard are found during such inspections and to propose appropriate penalties. Corn commented, however, that because inspections would be part of a good-faith effort, he "would anticipate that the civil penalties in these situations would be minimal or no penalties would be proposed, provided violations were not judged to be serious."

Making agreements on a plant-by-plant basis would not necessarily exclude employer associations from participation in the process of noise control. OSHA would continue to deal with these associations about noise problems on an industrywide basis. But the agreements would set forth in specific detail the steps any affected employer agrees to take, within a defined time frame, to come into compliance.

Guidelines for Collection of Long-Term Care Data

■ The U.S. National Committee on Vital and Health Statistics, a principal advisory body to the Secretary of Health, Education, and Welfare and to the National Center for Health Statistics, is currently sponsoring the design of national guidelines for the collection of much needed data on long-term health care.

These guidelines will probably take the form of a "uniform minimum basic data set," a specified group of data elements that describes some comprehensive class of persons, places, or events; that is required by the majority of users; that covers minimum or routine needs only; and that is uniformly defined and classified so that data collected at different places and times can be compared and aggregated.

Although not usually referred to as a minimum basic data set, the standard death certificate is a good example. More recently, the Department of Health, Education, and Welfare has helped to develop data sets to describe health resources (manpower and facilities) and to provide profile information on patients and their use of acute care hospitals and ambulatory care services. The projected data set on long-term care rounds out and complements the latter category of utilization data.

Stage one in the development of the long-term care data set was an intensive working conference held in Tucson, Ariz., in May 1975 under the chairmanship of Dr. Kerr L. White, Johns Hopkins University, School of Public Health, at which an interdisciplinary group explored the conceptual and methodological problems. The group included in its deliberations the mentally and physically ill, disabled, and impaired of all ages and considered the entire range of rehabilitative and supportive services, both institutional and noninstitutional. The recommendations of the conference are now being reworked and refined by a panel of technical consultants appointed by the U.S. National Committee on Vital and Health Statistics and headed by Dr. Ethel Shanas.

The great need for the panel, its parent committee, and the many interested persons who are to be consulted is to act promptly, The considerable public pressure that has built up for re-examination and reform in the general field of long-term care has created a growing demand on the part of providers of care, administrators, quality review groups, financing agencies, planners, and policy-makers at all levels for facts and figures. Without some standardization of content, terms, and classifications, the data collected in different information systems and special studies are like pieces of a puzzle that can seldom be fitted together.

Copies of the Tucson conference report, entitled "Long-Term Health Care Data," may be obtained from the editor, Jane H. Murnaghan, Department of Health Services Administration, Johns Hopkins School of Public Health, 615 North Wolfe St., Baltimore, Md. 21205.

New Health Manpower Act Is Described in Two Publications

■ The Bureau of Health Manpower, Health Resources Administration, has begun issuing fact sheets and other descriptive material on the new Health Professions Education Assistance Act of 1976. The measure, which cleared the White House on October 12, 1976, as Public Law 94-484, authorizes up to nearly $2.7 billion for health professions education over the next 4 years.

New provisions of the health professions education program total about $2.1 billion, but most of the new provisions will not take effect until fiscal year 1978. The law extends much of the current program through fiscal 1977, authorizing up to $607.9 million for the year.

General provisions of the new law are described in a 10-page article published in the expanded November issue of "Health Resources News," the official newsletter of the Health Resources Administration. A 24-page set of fact sheets on the major programs authorized by the law has also been published by the Bureau.

Copies of either of the two documents are available by writing to the Bureau of Health Manpower Information Officer, Room 5B-63, Bldg. 31, 9000 Rockville Pike, Bethesda, Md. 20014 or by calling (301) 496-6011.

Use of Contraceptives by Currently Married Women

■ Contraceptive use in the United States is increasing among married couples in which the wives are in the childbearing ages of 15–44 years. Whereas in 1960, 50 percent of currently married women were using contraceptives, data from the National Survey of Family Growth indicate that in 1973 the proportion of married women using contraceptives rose to nearly 70 percent.

The use of highly effective methods of contraception has also increased. Among couples using any method of contraception, the proportion using the pill, the intrauterine device (IUD), or sterilization rose from about 37 percent in 1965 to almost 70 percent in 1973.

Contraceptive use varied according to race, national origin, and family income level. Among white wives, 70.5 percent used contraceptives; among black wives, the proportion dropped to 60 percent. Among wives of Spanish origin, 65.5 percent were currently using contraceptives. However, the proportion of all black and white wives using the highly effective methods was about equal (about 48 percent).

Among the modern methods of contraception, the most popular method was the pill, used by 36.1 percent of the married women who were using contraception. Female sterilization was used by 12.3 percent of these couples, male sterilization by 11.2 percent, and the IUD by 9.6 percent. Other methods such as the diaphragm, condom, and foam accounted for the remaining 31 percent of contraceptive use. This study does not reflect the apparent current trend away from the use of the pill towards more conventional methods.

The study should provide much needed information to interpret trends in the birth rate and to provide guidance for efforts related to family planning and maternal and child health.

National Center for Health Statistics: Contraceptive Utilization Among Currently Married Women 15–44 Years of Age: United States, 1973. Monthly Vital Statistics Report Vol. 24, No. 7, supplement. DHEW Publication No. (HRA) 76–1120, Oct. 4, 1976. For single copies, call 301:443–NCHS.

New VA Hospital Designed to Remain Operational in Earthquake Aftermath

■ The Veterans Administration recently dedicated a huge new hospital in California that is designed not only to survive a major earthquake but to remain operational in the earthquake's aftermath.

The $83.7 million cruciform-shaped Wadsworth VA Hospital Center in west Los Angeles is constructed so that it can resist an earthquake of the magnitude of 8.5 on the Richter scale and continue to operate for 4 days without city water, electrical, or sewage services. The 20-acre hospital site is to serve as an emergency medical center in case of a major disaster in the area.

Using criteria developed by the Veterans Administration, the building's architects designed the structure to stay within prescribed "drift" or lateral motion limits during the shaking of an earthquake so that internal damage will be minimal.

The 900,000 square-foot building is constructed of a bridgelike grid of steel trusses on 16 seismic towers, which are, in turn, supported on more than 1,200 piers drilled 50 feet into the earth. The column spacing and the placement of air conditioning, electrical, plumbing, telephone, and pneumatic systems in "interstitial spaces" between patient-occupied floors will provide great interior flexibility for future modifications at low cost.

The new Wadsworth Hospital contains 21 diagnostic X-ray rooms, 10 surgical suites, an outpatient clinic capable of caring for 250,000 patients per year, and an automated computer-controlled delivery system for food and supplies. It will have the most modern nuclear medicine facilities in southern California. The institution will continue the old VA hospital's affiliation with the University of California at Los Angeles School of Medicine and a number of other medical research and training institutions.

The new structure replaces buildings that were razed after a VA study revealed them to be seismically unsound.

Seminar on Cardiovascular Epidemiology and Prevention

■ The Council on Epidemiology and Prevention of the International Society of Cardiology will hold its 10th Ten-Day International Teaching Seminar on Cardiovascular Epidemiology and Prevention in Ghana, August 21–September 2, 1977. Approximately 30 fellows can be accepted.

Nominees should be at the post-doctoral level, have some residency training or its equivalent, and be interested in cardiovascular epidemiology. Except in unusual circumstances, preference will be given to younger candidates with little or no formal training in epidemiology. Limited funds may be available to give partial assistance with travel costs. Room and board are provided without cost. Fluency in English is an absolute essential.

Once selection has been completed, should a candidate be unable to attend, no substitutes may be sent by the candidate's institution who have not been reviewed by the seminar committee.

A letter of nomination from the chief of the candidate's department or institution, a personal letter of application from the candidate, and the candidate's curriculum vitae should be sent in time to be received before the deadline for applications, May 1, 1977. These documents should be addressed to Jeremiah Stamler, MD, Chairman of the Council on Epidemiology and Prevention, ISC, Northwestern University Medical School, Rm. 9-105, Ward Bldg., 303 East Chicago Ave., Chicago, Ill. 60611.

The seminar is held under the auspices of the International Society of Cardiology in association with the World Health Organization and local hosts.

NEW TEST MAY HELP MORE TO SURVIVE OVARIAN CANCER

■ A specific substance that seems to be present in a woman's serum when she has cancer of the ovaries (crystadenocarcinoma) may be the key to detecting the disease early enough to reduce significantly its mortality rate. Work by Malays Chatterjee, PhD, senior cancer research scientist, and Joseph J. Barlow, MD, chief of the Department of Gynecology at Roswell Park Memorial Institute (the New York State Department of Health's comprehensive cancer center in Buffalo), indicates that the ovarian cystadenocarcinoma-associated antigen (OCAA) may be helpful for both diagnosing the disease and monitoring a patient's response to treatment.

A reliable early detection method is desperately needed. Of the 17,000 women in the United States that ovarian cancer was expected to strike in 1976, the American Cancer Society estimated it would kill almost 11,000. Most of these women die because their cancer is discovered too late for treatment to be curative.

Early detection allows for removal of the ovaries or the initiation of effective radiotherapy or chemotherapy before the cancer spreads from the ovaries to other parts of the body. Because ovarian cancer does not produce symptoms in its early stage, detection at its start is a rare and lucky occurrence.

Chatterjee and Barlow found that all of the antigens that have been detected in patients with ovarian tumors, with the single exception of OCAA, occurred not only in patients with these tumors but also in patients with other kinds of gynecological cancer. Thus, it seems that only OCAA can be relied upon as a diagnostic marker specific to cystadenocarcinoma alone. Also, OCAA seems not to be present in patients with tumors of the ovary that are benign. Another important consideration is that OCAA is immunologically distinguishable from other cancer-associated antigens, including the carcinoembryonic antigens associated with cancers of the colon and of the rectum and the alpha fetoprotein associated with liver cancer.

According to Chatterjee, "What we have to do now is to devise a very sensitive OCAA detection and followup test and prove beyond question its reliability by using it on larger numbers of patients."

The Roswell Park researchers will continue their work under a contract with the National Cancer Institute that calls for "The development of an immunodiagnostic method for the early detection of ovarian cancer in asymptomatic women." Immunodiagnostic tests rely on the fact that antigens bind with antibodies produced by the immune system in response to them. In such tests, serum from the patient is exposed to antibodies against OCAA. Radioactively labeled OCAA is then added. It will compete with OCAA that is present in the patient's serum for binding to the antibody sites. The higher the concentration of OCAA in the patient's serum, the smaller will be the amount of radiolabeled OCAA that is bound. The resulting decrease in the level of binding activity gives a very sensitive indication and measurement of the OCAA in the patient's serum.

The diagnostic value of OCAA will be confirmed if radioimmunoassay results show that OCAA is always present in women with ovarian cancer but is not present in women with nonovarian cancer, in women with benign tumors, or in women who are disease free. OCAA's usefulness in monitoring a patient's response to treatment will be demonstrated if further testing shows that OCAA consistently increases or decreases with the size of the tumor.

"We're hoping," Chatterjee said, "that in a few years we might have a detection and followup test that can be put to work to help more women survive ovarian cancer."

VD Includes More Than Syphilis and Gonorrhea

■ "Sexually Transmitted Diseases," a recently published 24-page pamphlet, summarizes current information on these widespread infections. This publication of the National Institute of Allergy and Infectious Diseases explains the causes, symptoms, diagnostic tests, complications, and treatment of several types of venereal or sexually transmitted diseases that plague 8 to 10 million Americans each year. Even with increased efforts in VD control, the two most well-known forms of the disease—syphilis and gonorrhea—still exist as significant health threats.

As the pamphlet stresses, the term VD covers a wide range of diseases, all with different symptoms and treatments, but all believed to be transmitted, at least sometimes, through intimate sexual contact. For example, VD includes genital herpes, nongonococcal urethritis, chancroid, trichomoniasis (a cause of vaginitis), granuloma inguinale, crab lice, scabies, and cytomegalovirus infection. This last named entity is an important cause of mental retardation in infants infected before birth. Even hepatitis B, or serum hepatitis, is now recognized as being contracted sexually on occasion, as well as through the administration of contaminated blood.

Despite progress in combating VD with the use of antibiotics, some organisms causing these diseases have become drug-resistant and others have long defied investigation. The pamphlet touches on recent research approaches to acquiring in-depth knowledge about these elusive organisms; it contains an easy-to-follow 2-page chart summarizing currently known or suspected VD agents and the diseases they may cause.

Sexually Transmitted Diseases. National Institute of Allergy and Infectious Diseases, DHEW Publication No. (NIH) 76–909; 40 cents, with a 25 percent discount for 100 or more copies, U.S. Government Printing Office, Washington, D.C., 20402. Single free copies available from Office of Research Reporting and Public Response, National Institute of Allergy and Infectious Diseases, Rm. 7A–32, Bldg. 31, National Institutes of Health, Bethesda, Md. 20014.

Medical Malpractice Cases Analyzed in NCHSR Report

■ "How Lawyers Handle Medical Malpractice Cases" offers, for the first time, an analysis of the legal aspects of malpractice covered in the massive "Report of the Secretary's Commission on Medical Malpractice," published by the Department of Health, Education, and Welfare in 1973. The analysis was produced by Dr. William J. Curran, professor of legal medicine, Harvard School of Public Health, under contract from the National Center for Health Services Research.

The original DHEW study was based on a nationwide survey of 809 lawyers. Curran's findings reveal that lawyers rejected 88 percent of the medical malpractice claims they review. The most common reason for rejection of a claim, cited by lawyers 41 percent of the time, was "no perceived liability."

Money is awarded to the plaintiff in 68 percent of the cases that are accepted. The average gross recovery, Curran points out, was $22,000 with a median recovery of $3,500.

The NCHSR study confirmed several ideas acknowledged by the legal profession, but not widely known elsewhere. For example, there are few attorneys who actually specialize in medical malpractice litigation; the "contingent fee" system, usually a fixed rate of one-third of the amount recovered, often results in rejection of cases that have merit but are not economically feasible to pursue; and juries generally understand the medical issues in a malpractice case although they understand the legal issues to a lesser degree.

Curran also says that the study thus contradicts certain beliefs held in the medical profession about malpractice cases. For example, assumptions such as "there are huge numbers of plaintiff's attorneys all over the country making very good incomes out of the malpractice field," and "juries are favorable to the injured patient and prejudiced against the rich doctors and insurance companies" were refuted in the original HEW report.

In addition to analyzing the report, Curran offers comments on the need for updating the DHEW study, the first of its kind ever conducted in the United States, and also makes some observations on future reforms in the medical malpractice field. He recommends further research into the claims screening process, how clients actually get to lawyers, delayed settlement practices, and the necessity for comparing data on malpractice litigation with those available on other types of personal injury litigation.

How Lawyers Handle Malpractice Cases by William J. Curran, DHEW Publication No. (HRA) 76-3152. October 1976, 46 pages. Copies available from National Center for Health Services Research, Rm. 15-36, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md. 20857.

Industrial Waste Conference at Purdue, May 10-12, 1977

■ The 32d Annual Purdue Industrial Waste Conference will be held May 10–12, 1977, in the Stewart Center at Purdue University, West Lafayette, Ind.

More than 100 technical papers will be presented on various subjects relating to industrial waste treatment. More than 800 national and international conferees from industry and education and government institutions are expected to attend.

Information about registration and attendance may be obtained from Prof. A. J. Steffen, Rm. 310, Civil Engineering Bldg., Purdue University, West Lafayette, Ind. 47907.

Advance Data From NCHS Surveys on Blood Pressure and Hypertension

■ The National Center for Health Statistics, Health Resources Administration, is now publishing selected findings from its health and demographic surveys in a new publication "Advance Data From Vital and Health Statistics." This new mechanism for early release of selected survey data replaces the supplements to the "Monthly Vital Statistics Report" and provides a more appropriate title for this material as well as a link to the "Vital and Health Statistics" series in which the final data will appear. Provisional statistics from the registration systems as well as advance reports of final data will continue to be published in the "Monthly Vital Statistics Report."

Concurrently, the Health and Nutrition Examination Survey (HANES) and the Health Interview Survey (HIS) have published reports on blood pressure and hypertension. HANES data (from direct examination, medical history, tests, and measurements) cover the period April 1971–June 1974; HIS data were obtained through personal interviews during 1974.

The estimates of hypertension from the two surveys are similar even though different survey methods and different definitions were used to obtain the data. An estimated 23.4 million persons aged 12–74, including 23.2 million (18.1 percent) of the adults aged 18–74 have definite hypertension, either a systolic blood pressure of at least 160 mm Hg or a diastolic blood pressure of at least 95 mm Hg, according to HANES. HIS estimates show that 22.6 million persons aged 17 and over (15.7 percent) reported that they were told by a physician that they had hypertension. Both surveys show that the prevalence of hypertension increases with age and that proportionately more blacks than whites have it.

HIS further analyzes hypertension data by family income, education, geographic region, residence, number of physician visits and days in bed for the condition, and interval since last physician visit. The HANES summary includes data on whether a physician had ever told the person that he had high blood pressure, on the use of medication for hypertension, and on mean systolic and diastolic blood pressure measurements by age, sex, color, family income, education, and geographic region.

Blood Pressure of Persons 6–74 Years of Age in the United States. Advance Data No. 1. Hypertension, United States, 1974. Advance Data No. 2. To receive Advance Data regularly, contact the National Center for Health Statistics, Rm. 8-20, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md. 20857, telephone (301) 443-1200.

FDA Proposes Phaseout of Chlorofluorocarbon Propellants in Aerosols

■ In response to scientific reports confirming the adverse environmental effects of chlorofluorocarbon propellants in aerosol products, the Food and Drug Administration (FDA) will take the following actions:

1. Propose an orderly phaseout of all nonessential uses of chlorofluorocarbon propellants in food, drug, and cosmetic products.
2. Pending elimination of chlorofluorocarbon propellants, require an interim warning label on all food, drug, and cosmetic containers using such propellants stating, "Warning. Contains a chlorofluorocarbon that may harm the public health and environment by reducing ozone in the upper atmosphere."

The proposal to require the label warnings was published in the Federal Register November 26, 1976. Comments may be submitted within 60 days to the Food and Drug Administration. The warning statement would become effective 30 days after issuance of a final regulation.

The FDA estimates that of the 2.4 billion self-pressurized containers sold in the United States annually, the proposed warning label would affect about 1 billion. The remainder of the containers either do not contain chlorofluorocarbons or are products not regulated by the FDA.

". . . chlorofluorocarbon propellants primarily used to dispense cosmetics are breaking down the ozone layer," FDA Commissioner Alexander M. Schmidt pointed out. "Without remedy," he said, "the result could be profound adverse impact on our weather and on the incidence of skin cancer in people. It's a simple case of negligible benefit measured against possible catastrophic risk, both for individual citizens and for society. Our course of action seems clear beyond doubt." The Commissioner therefore concluded "that FDA should set in motion the regulatory processes for which it is responible in order to begin the reduction and eventual end to the nonessential uses of chlorofluorocarbon in food, drug, and cosmetic products."

Study of Cancer Screening as a Health Insurance Benefit

■ A project to devise a cancer screening program that can be included as a benefit of health insurance is underway by the Blue Cross Association (BCA), the coordinating agency for the 69 Blue Cross Plans in the United States. The National Cancer Institute has awarded the association a 3-year contract for the project, which was begun in August 1976.

"In the past," said Dr. Diane J. Fink, director of the Institute's Division of Cancer Control and Rehabilitation, "routine screening has been regarded as yielding a low rate of detection and therefore has been too costly for coverage by health insurers and other third-party payers." Ways in which cancer screening can be made cost effective will be explored in the BCA project. Steps will include:

1. Evaluation of the costs of the screening tests and early treatment in comparison with the costs now incurred to treat cancer.
2. Analysis of current screening programs financed by the Federal Government, industry, labor unions, and prepaid health plans.
3. Development of criteria for selection of the cancer sites, target populations, and kinds of tests offering the greatest potential for early detection.

When BCA has created a model screening program, it will prepare guidelines on how to operate such a program. For example, standards will be written for various types of medical settings, such as health maintenance organizations, hospital outpatient clinics, or industrial-labor union facilities.

Of particular interest will be criteria for the use of various types of health personnel in the screening program: physicians, nurses, and allied health personnel. Efforts will be made to lower the costs of cancer screening by the use of allied health personnel in various noninstitutional settings.

As part of the project, BCA will also prepare educational materials to inform both providers and subscribers about the new cancer screening benefit and to motivate them to use it.

Once this planning phase has been completed, BCA will arrange for demonstrations of the benefit package by Blue Cross Plans, and data will be collected for evaluation of costs under various circumstances.

If the results show that cancer screening can be economically provided, BCA will offer the coverage to its national accounts and will encourage all its member plans to participate.

Interview Survey Collecting Weekly Data on Influenza

■ Weekly national estimates of influenza-like illnesses, bed-days associated with such illnesses, and influenza vaccinations are being issued this winter by the National Center for Health Statistics, Public Health Service. The national estimates are being published approximately 1 week after the data are collected. The collection of these special data is cosponsored by the Center for Disease Control, Public Health Service, which has the primary responsibility for monitoring the incidence of influenza and the administration of the swine influenza vaccine in the United States. The first weekly report was issued November 2, 1976, and the reports will be continued through March 1977.

The data are collected in the National Health Interview Survey (HIS). Each week a probability sample of households representing the civilian noninstitutionalized population of the United States is interviewed by trained personnel of the U.S. Census Bureau. Interviewing is done continuously in weekly samples of about 800 households. For purposes of this rapid reporting system on influenza and inoculations, a supplemental set of questions was added to the end of the regular HIS interview beginning the last week in September.

For additional information or copies of the reports, contact the National Center for Health Statistics, Scientific and Technical Information Branch, Rm. 8-20, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md. 20857. Telephone (301) 443-1200.

Materials Available for Poison Prevention Week

■ In connection with National Poison Prevention Week, March 20–26, 1977, the Education Committee of the American Association of Poison Control Centers has announced that the following materials are available:

• *Slide talk,* "Our Poison Jungle"—44 slides, 35 mm, color, with annotated script. Covers incidence, hazards, preventive measures, and first aid suggestions ($16).

• *Filmstrip,* "Our Poison Jungle"—44 frames, color, for grades 3–5. Includes curriculum guide and recommended script. Script also available on cassette tape. Discusses hazards in home and how to prevent accidental poisonings ($9; 10 or more $8.50 each; cassette tape for filmstrip $4).

• *Captioned slides* (new)—30 slides, 35 mm, color, with captions. Suitable for use in automatic projector with self-contained screen. For display in clinics, at health fairs, and so forth. Covers prevention and emergency procedures ($11.50).

• *Activity book*—12 pages, for ages 5–10. Includes games, puzzle, maze, and pictures for coloring. Directed at teaching poison prevention safety rules (50 cents each; payment must accompany order unless ordered with slides or filmstrip; quantity prices on request).

• *Poster,* "Syrup of Ipecac" (new design). 17 by 22 inches, color. Urges parents to keep syrup of ipecac on hand in case poisoning occurs and physician recommends its use (100 copies $15.00—minimum order).

• *Flyer,* Syrup of Ipecac—5 by 7 inches, 1 page, color. Urges parents to keep syrup of ipecac on hand in case a poisoning occurs and physician recommends its use. (Single copy free; may be used for quantity printing locally).

• *Pamphlet,* "Poison Isn't Kid Stuff"—3½ by 7 inches, 4 pages. Suggests dangerous household products be kept away from children and when a poisoning is suspected, medical advice be obtained. (Single copy free; may be used for quantity printing locally).

• *Pamphlet,* "When Times Get Hot & You're Under Stress"—3½ by 8½ inches, 4 pages, color. Lists the stressful times when accidental poisonings may occur and urges parents to be more alert at those times. (Single copy free; may be used for quantity printing locally).

• *First Aid for Poisoning card*—5 by 8 inches, blue and white. Instructions for handling poisoning emergencies. (200 or less free; may be used for quantity printing locally.) Courtesy of Plough, Inc.

All requests for these materials should be made to American Association of Poison Control Center. Education Committee, c/o Academy of Medicine of Cleveland, 10525 Carnegie Avenue, Cleveland, Ohio 44106.

7th International Congress of Dietetics to be Held in Sydney, Australia, in 1977

■ The 7th International Congress of Dietetics to be held in Sydney, Australia, from May 4 to 10, 1977, will be hosted by the Australian Association of Dietetics and the New Zealand Dietetic Association. The theme of the congress is "Dietetics Around the World," and international authorities on food and nutrition have been invited to present the keynote papers. The sessions will encompass current practices and innovations in nutrition education, food administration, applied dietetics, and community programs.

In keeping with the congress's theme, papers will be presented on food habits and their history, nutritional problems, and nutritional care in different countries. The sessions on nutrition education will focus on the basic techniques and skills of communication, motivation, education, and evaluation. One day will be devoted to problems of food administration. The applied nutrition and dietetics sessions will highlight the clinical consequences of dietary imbalances of one or more of the following: calories, sodium chloride, vitamins, sugar-alcohol, iron and calcium, texture-fiber-consistency, fat, and trace elements.

In the final session the discussions will focus on the evaluation of community nutrition education programs, the identification of vulnerable groups, implications for dietitians and nutritionists, and consumers' fears regarding today's foods. Papers and discussion groups of specific interest to younger dietitians will be included.

A circular, including the program and details of travel, tours, and accommodations, together with an enrollment form, is available from Dulcie Stretton Associates, International Dietetics Congress Secretariat, 70 Glenmore Rd., Paddington, N.S.W. 2021, Australia.

education note

Continuing medical education institute. Sea and Shore Seminars of Washington, D.C., the Charles R. Drew Postgraduate Medical School, and the Office of Continuing Medical Education of the University of Cincinnati College of Medicine are sponsoring a seminar, "The Changing Seasons of Life: The Physician's Role."

The course is scheduled for April 23–30, 1977, aboard the SS *Rotterdam,* from New York to Nassau and Hamilton, Bermuda. The course is acceptable for 25 credit hours in Category I for the Physician's Recognition Award by the American Medical Association and for 25 prescribed hours of instruction by the Academy of Family Physicians.

Registration fee is $175 before February 23, 1977; after this date the fee is $200. Further information may be obtained from Sea and Shore Seminars, 2100 19th St., NW., Rm. 601, Washington, D.C. 20009. Attention: N. H. Chamberlain.