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Some examples of the kinds of errors to be found in the transcripts are provided below.

Filename	PDF Version Page	Error
jmf_int_transcript_Williams_2_2_1976.pdf	20	"Parkalnd"
jmf_int_transcript_Foster_2_2_1976.pdf	2	"trememdous reseurce"
jmf_int_transcript_Neaves_1976.pdf	6	"Andreas Baselius"
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TAPE EDITED REVIEWED 5/8

Dr. Schermerhorn Allied Health

It would be useful because a number of the programs developed from the medical school.

?evolution lead in?

All right, the Allied Health programs at this school started well before they were formalized as educational units. Two of them were pretty closely associated with physical medicine and rehabilitation, physical therapy a really well-defined kind of program was running through Baylor but with close relationships with the P M and R department here, and the other program that came out of that area would have been Rehabilitation Science and ultimately counseling. Because in P. M. and R there is a fair need for dealing with the mental problems of the disability, and so our ~~Physical~~ physical therapy program was brought in from Baylor Hospital and formalized as an academic program.

NG. JET NOSE

At the same time our Rehabiliation Science Department was established and took on initially very limited types of education that were needed to produce people to counsel and other, do other things in the rehab area. Physical Therapy has continued in pretty much a standard pattern because that mold is defined by the professional groups, but the rehab science has gone in all directions, and I don't know if you're familiar with all the things that are happening in there, but our rehab science now has a track that takes people through mental retardation, through work evaluation, through evaluation of handicapped people for work capacity, work retraining. We have a track now for rehabilitation of people of the deaf. We will start this next fall with rehabilitation of alcoholics, and so, see that one

?_____?

Schermerhorn Add 1

...just from a little seed really from the limited needs that PM&R had , that is, the rehabilitation of people, generally with stroke or with cord injury or something like that, and the management of their needs, their employment needs and their work retraining, if necessary, become far more specialized in mental retardation and in other aspects of disability that aren't quite so common in PM&R. The program really has involved and today is one of the largest programs in the school.

We have also out of that department the masters program in rehab counseling which is one of only two in the country I guess that are based at a health science center. Most of them are based in schools of sociology or sometimes even education, but one or two others in the country in health science centers. And we have also now become very active in the continuing education area here and are quite heavily funded. We are funded now in the amount of about $125,000 a year to provide continuing education of a formal nature both here and in locations in a five-state area.

?Five-state area?

REHABILITATION SCIENCE
PHYSICAL THERAPY
NUTRITION
?

Yeah. We serve pretty much as the prime job upgrading agency for the federal government in Arkansas, Louisiana, Oklahoma, New Mexico and Texas. And that itself now has become almost a department. We've got three or four people in there who do nothing (really) but travel and present workshops in various parts of this five-state area. Also picked up when the school was formalized was a nutrition dietetics program (which) had a nonacademic base at Parkland Hospital before hand and the med tech programs which was based at Parkland.

nucleus

Those four programs were the nucleus of the school. And they were sort of ready-made kinds of offerings to build a school around. And I know I came here in 1971. The school organization

had started two years before. And I got here just two days before the first commencement, and here going across the stage [redacted] something like 30 or 31 or 32 people, and since that time we have grown some.

?How many now?

Oh, this last year there were about 110 or 115 and probably about 125 next year.

?Several different programs?

Yes. We're beginning [redacted] more to stabilize at this time our expansion of programs like med tech and physical therapy have halted for the time being, and probably for a good long time. Our nutrition program which has changed now has filled up its pipeline. Our physicians' assistant program has filled up its. And we're growing in only a few areas now.

?Those running capacity?

Yeah. Physical therapy we have expanded slowly from 24 to 30 to 36, and we'll probably stop [redacted] because one of the strengths of the School of allied health sciences is that it doesn't enroll any people who can not be placed in a clinical training facility. A general academic institution may say, "we have enrolled in our program 250 students," but what they're talking about is people who as freshmen say, "I think I'd like to be a med tech," or as sophomores or as juniors, but of the 250 that are enrolled, maybe only 12 or 15 will ever find their way into a hospital school for a training program that will allow them to become registered as med techs. The others will drift off into something else. But we admit no one here unless we can guarantee that if they perform effectively, they will reach the goal that they have set out to reach, or we don't enroll anyone in the physical therapy program

if the, well, I should say it differently, we don't enroll anyone in the physical therapy program with the intent of letting them drop by the wayside. But we know when they're enrolled that there's a clinical slot for them when the time comes, same with med tech and the same with nutrition.

?Clinical slot in training?

That's right.

?Relationship between students you turn out and demand?

Well, that's another thing that needs to be a matter of concern sometime in the future but not yet because we are not producing enough to satisfy the local demand. And we see surveys from the Dallas hospital council twice a year and in every instance there are openings in each of the areas in which we prepare students. Moreover, our graduates are most generally placed before they graduate, which is a clear sign of continuing need. I know of one student who was not placed from one of the programs, but that's not because there aren't jobs available but for other reasons. But other than that our graduates are hired before they graduate which is a clear sign of continuing need.

START HERE

The start of the four programs that form the nucleus of the school was sort of significant because much of the training that they were receiving prior to the establishment of the school was kind of volunteer training by physicians and other personnel in the hospitals. Much of the cost was being borne by the hospitals and clinical facilities, and it was not really an altruistic kind of effort. It was an effort to produce people who would work in the hospital afterwards so they figured that they were investing. Nowadays hospitals are unable to budget

money for things like this because they can't recover it in third party payments. When you calculate the hospital rate for Blue Cross-Blue Shield and for medicare-Medicaid and the other things, you can't put a big lump of money in and say this is for training, and we'll divide that up among all the patients. That's not an acceptable charge, so more and more schools of allied health are assuming the cost of education, both materials and personnel. And really puts them in a much more responsible position because now they have to maintain liaison with the hospitals or the users of these people to make sure that the product that we're producing is the product that they need. That's sort of what happened to the nursing system. They weren't staying close to the people that they were training personnel for and the hospitals were complaining that they weren't getting nurses, that they were getting some sort of a person trained to do lots of things but not care for patients, and the nursing system didn't hear it or they didn't listen really carefully, and the result was that they got upended.

?Relationship between nursing and allied health professionals?

Just about nothing.

?Should there be?

Well, the evolution of allied health has in part effected a pretty clear split between nursing and allied health. At the beginning, there is no beginning, but back in the development of the health care delivery system was the physician and the nurse and odds and ends of other people, and when a particular patient care kind of thing came along, the nurse was the one who was assigned to do it, if it was turning the patient in bed to

This is an important point perhaps best illustrated with shortages of hospital techs at work

keep them from getting pneumonia or making the iron lung work for the person who had polio or a wide variety of things. The nurse did a lot of it if it was...even collecting body samples for the laboratory, the nurse would probably be doing most of that. Well, as patient care got more complex, and as more and more procedures supporting procedures were developed, it wasn't possible for the nurse to do it all. So pretty soon there came a little category of people who would be respiratory therapists, a category of people who would collect laboratory specimens, and all sorts of categories along the way, and these in turn developed more and more into identifiable allied health professions. Well, as that development came and the nurse was relieved of a particluar duty. Then pretty soon a chasm began forming, and the nurse in charge of whole patient care from the start of the shift to the end of the shift, then overseeing everything from medication to being sure that they got their food to being sure that they got whatever special procedures were concerned. The nurse became in some respects, I suppose, in an overseeing capacity, but clear lines and divisions arose between these various other professions and nursing. Coupled with that has been the recent strong moves in nursing to become less involved and, well, less responsive and less controlled by the physician. The nurse has been reaching more for an independent kind of practice, and he, because lots of men are in nursing, are looking more and more toward their own professionalism. And have been moving away from allied health, more and more clearly. It takes us now, I don't think anybody really knows what's going to happen, but it's quite clear that curriculum development is going to be dictated by people other than nurses, and a training

useful background

emphasis is going to be dictated by people other than nurses. And nursing has really suffered a serious setback in this state. Same thing is really happening with allied health now. We're beginning to see people in allied health, different groups, who are saying, who started out supplementing the health care dictated by the physician, but look at how well-prepared we are now and how competent we are, we're going to start looking at a little private practice ourselves, and so to a lesser degree, we're seeing in allied health what happened in nursing. And every time somebody does this, and talks about doing their own thing, they're also talking about charging a fee for it and you go to the hospital now, and you get a bill from the pharmacist and from the laboratory person and from the radiologist and from the respiratory therapist, you end up with a pretty terrific hospital bill, so those are some of the problems that nursing has not coped with well in this state and hopefully we will, but that's a long answer to your question that nursing stands apart from allied health. just as pharmacy stands apart.

?Background of conflict between nursing and physicians' assistant?

Well, that's sort of an editorial fear because when physicians' assistants work with nurses, they work well together and are almost uniformly well accepted. Legend has it that back in the late 1950's and very early 1960's many people urged the nursing profession to begin to prepare some people to perform these specific kinds of tasks. They're done in other countries--midwifery, for example, sp? and the Felcher type of health care delivery practiced in Russia and the other eastern European areas. And it was clear there was a need for some sort of a person who could assume a lot of the

P.A.

routine and repetitive tasks that physicians were performing. Physicians shouldn't have to take throat swabs and shouldn't have to run routine urinalysis in his office and probably shouldn't have to give shots and probably shouldn't have to do a lot of other things when his skills are needed at a higher plane, and if it's a repetitive kind of task, the odds are that someone who does it more frequently will do it better than the physician.

Well, nursing was right at its metamorphosis then. It was right at the point where it was beginning to think about an independent practice, at the point were it was beginning to strain at the apron strings to the physician and be recognized in its own right. And they viewed this kind of development as a step backward in their development, and so they refused to be a part of it. Duke University then said, "Well, all right, fine, we'll train our own people to do what we have identified as a needed task, and they did, and the concept began to expand and it began to encompass returning medics from Korea and from Vietnam, and has gradually now crystallized into a formal educational program with a product that is clearly defined with a credentialing examination administered by the National Board of Medical Examiners and it's a profession that might not have had to develop had it been possible to utilize an existing health profession because there really isn't all that much difference between the nurse and the p.a. except that the nurse is continuing to move in the direction of independent practice, and the p.a. cannot. The p.a. by law must be accountable to a physician and must work only under the direction of a physician, so....

Ann: We've had more than one doctor going around telling that his nurses are his p.a.'s.

And they really are, too.

?P.a. paid better than R.N.?

I rather suspect that it is unless a physician, if you've talked with a physician who says that his nurse is his p.a., and he obviously prizes the lady, then she's being paid as well as a p.a. If a physician just says, "Well, nurses are prepared, and I use them, and I use them for p.a.'s," then the odds are, they're not being paid as well.

?Allied health changing, under control?

No, it's not difficult to control. We have calls monthly from different people in the medical school. Dr. Fordtran called a few months ago and said, "You know, we really have a need for a program to prepare gastroendoscopists, people that put down....

?Fordtran yesterday?

That's great but Dr. Fordtran called because he needed one, and around the city there are three or four more needed. Dr. Peters will talk to us and say, "Why don't you all produce some good technician to help with catheterization and things like that? to help me in my clinic?"

And Dr. I don't remember his name who runs the dialysis center says, "It would be useful if there were a program that would produce a few technologists to work in the kidney dialysis unit, and from all sides come little requests like this, and these are things that we don't generally get involved in because they're tiny in themselves, but ultimately some way or other the school will find a way to respond and it looks as though we have found a way, and that should be through the mechanism of the health magnet high school because that health magnet high school takes people ~~in~~ in the ninth grade

and runs them for four years. I sat on the task force for that school, and I suggested (sometime ago) that it would be logical to take the first couple years of that time to begin to screen people and to begin to identify people who might be good vocationally trainable who probably did not or could not go on to college, and along about the end of the second year begin to pick those people out and to direct their training a little bit so that then the senior year, one or two or three could go to John Fordtran and one or two or three could go to Paul Peters and to the other places where a limited number of technicians are needed, and so in that respect allied health can even steer people in at different levels because we sit close enough to the medical profession's needs and we hear them so that we can make some kind of judgments as to where they get their help. This would be valuable to those people who need technicians because now it takes away a lot of the elements of chance. If John needs somebody over there and has no other source, he's going to ask personnel to get him someone, and he's going to bring that someone in and interview them and then decide whether or not he thinks he can do it, and then go through a training program starting with terminology even. And he may or may not win. He may find after five or six months that he's got a nontrainable person, but if we take someone through the high school and bring them up in this climate right along, the odds are much better for success.

At the other end we have been urged now for three or four years to begin to prepare nuclear technologists. The need for technical people in this field is growing. Parkey over in radiology is now starting a nuclear medicine residency, a nuclear radiology

residency. Dr. Frenkel has great need for technicians. The hospitals around the area are needing people trained in this area. So for the first time now in three or four years we have responded by preparing a proposal for the regents which is on its way now designed to institute such a program at the baccalaureate level. If it's approved, then we'll go on to the coordinating board in April, and if that's approved, then we will be starting in September to plan and offer such a program. So that's how a program will evolve. It evolves based on a need. We don't go down the shopping list and say, "One of those and one of those and one of those," but rather we concentrate on what we're doing. We also keep listening to see what is not being done that ought to be done. The School of Allied Health evolves generally in that fashion. I think it's one of the real advantages for having such a school in a health science center where you can communicate back and forth and where you really can respond rather quickly to community needs. If you're isolated from the health science center, then there are third parties involved in transmitting those needs. Maybe you don't read about it in a journal someplace until six or eight months later, and then by the time you get through your planning and go back around the circle, other programs have developed that may not be as good as the one you produce or some other alternative approach to the thing has been found which may be good because that would mean that you didn't need the program anyway, but just in general the interaction between medical school and school of allied health and the community because when you're part of the health science center, you're also part of the community, and people talk back to you and there's an interchange and it seems that the

need and program development

HEALTH SCIENCE CENTER INTERACTION

arrangement is not only a symbiotic kind of arrangement, but it's also one in which you really have a clear pipeline to what's going on and to what has to be done or what should be done that isn't being.

?Students that enter your program have finished high school?

Two of our programs , three of our programs require 90 hours, three years of college. That's med tech, physical therapy and Bill Winson's instructional media.

All of the others require a minimum of 60 hours although in most of the others we have people coming in who may have a baccalaureate degree.

?Changes in rehabilitation at the bachelor's level?

Yes,...

? That program and the health care administration program changed the most?

GERONTOLOGY

Oh, I haven't talked about the health care administration. That's an exciting one.

?Difference between a technician and a technologist?

Well, I'll give you my definition. A technician is someone who is trained to perform a group of procedures, not why do you do them, not what are the principles behind them, not anything except that you go step one, step two, step three, step four, and you're there. A technologist is one who understands more the underlying theory of a particular procedure or whatever it is that he's doing, who understands what may happen if the procedure is modified or altered, who is able to make some judgmental decisions in the process, who has a higher amount of theoretical knowledge to work with, and that's the way I distinguish between them.

delete

Technician: OS technologist

We prepare no technicians here. We prepare what I described as technologists, in a variety of different areas. We not only tell them and show them how to do things, but the rationale for that prodcedure, the alternatives and so forth.

?So they'll be able to do other things?

And so they'll be able to function with a lesser amount of supervision, because the technician will more often than not be unable to comprehend the effects of a misstep or may not even be able to recognize when something is not going correctly....

....

He's a pretty remarkable fellow. This is....

?Back a second. Nontraditional programs?

Well, from an administrative point of view the most exciting ones because they allow much more creativity than those that fall onto a tight pattern. Physical therapy has guidelines that everyone must follow. You must have in your physical therapy a certain number of elements in order to have an accepted program. You must follow a certain type of curriculum sequence and all sorts of things. Med tech, the same way. Nutrition, even the same way.

But things like rehabilitation or health care administration which is now gerontologic services administration have no patterns. There are no , there's no book written on how you do it, so what you do depends on the creativity of your faculty. What's happened in our rehab science program is a clear example that a good faculty can uncover so many areas where trained people are needed and have not been prepared before and can provide so many outlets for career development that people are actually searching for.

Gerontologic Services Administration appears to be going in

more

the same direction. The government is becoming more and more interested in aging, and more and more frustrated with the medical community because the medical community doesn't acknowledge aging as an entity of any sort, and so consequently concerns itself with the symptoms of aging and the treatment of the symptoms. Here we push it more as being a state in which certain specific sets of circumstances exist that often can be modified and often be adapted to serve the needs of the elderly, and we approach gerontologic problems here in allied health as a clear identifiable field. The physician approaches it quite differently, as a series of conditions that develop as a result of a person growing old. The government is very eager to support good kinds of research in this area, and there has been increasing desire on the part of the public to be educated in this area, so we've had the the program for three years. We have confined our efforts pretty much to preparing nursing home administrators, but now we're about to branch out and move into broad areas in which we'd be able to provide a good solid training for people who are going to work with the aging in a variety of settings--community centers, nursing homes, referral centers. We will cross lines with rehabilitation and get into work retraining aspects for the aging. And so two programs will have many points of interlock as they go their own way. One of the very interesting things about programs of this sort are that they attract a large number of older students. In rehab the the average age of the student is about 29. That means that there are a lot of second career people in there.

Gerontologic services is showing signs of doing the same things except we also are attracting a number of young people to it.

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?More problems trained to deal with?

In gerontologic services?

?Yes?

Well, I think that's something that you really need to talk to sp? Dr. Whitemar about because I wouldn't want to put words in his mouth and his program is new. He's been here since the middle of the summer. And some of his ideas are still evolving, and it wouldn't be fair to me to say what I viewed his direction as, it would be better for him to do so.

In addition to gerontologic services we have another sort of nontraditional program here which is designed to prepare both technicians and technologists to teach their particular skills, and we call it teacher education. And our approach to it is a dual approach--we provide the student with a good solid foundation in education, educational psychology, test construction, testing and measurement, things of that sort that are the tools of teaching.

We provide them also with an upgrading in whatever was their area of technology. We're concentrating at this time, for example, on those people who are going to teach radiologic technology and those who are going to teach respiratory therapy and also those people who are going to teach dental hygiene. And in each case we work to provide them with technical background as well as with teaching background to elevate them above the level of practitioners, and in that way we think that we are contributing to the educational effort at this time mostly at the junior college level because most of these are the associate degree technologies that we are dealing with, but we are preparing

now to move into the graduate area for those people who hold baccalaureate degrees now who are going to teach med tech or who are going to teach physical therapy or nutrition.

?Response to a need?

This is in response to a need that we have viewed ourselves because to try and hire someone in physical therapy, for example, at a graduate level is the most difficult thing in the world. There isn't a month goes by that you don't pick up the employment opportunity journals and see one after another physical therapy people requested. One after another nutrition people requested. There are some real shortages, and the junior colleges it's even more critical because they don't have a health science center orientation. El Centro is a perfect example. They know that there is a need for health education, but they don't have people there who have good access to the community, and so consequently, if they're going to have a rad tech program, they go tapping people on the shoulder who are rad techs and say, "We need a teacher. Do you want to be it?" and the quality of their instruction even though it may be well-intentioned, is often less than effective. And so many of the people we prepare in this program will go into settings such as that, and they'll go in now with skill and competency and with an understanding of what their objectives are, which isn't always the case when you get an on-the-job instructor.

And then for a very limited number of people, Bill Winn and Bill Christenson's area in biomedical communications, specifically medical illustration, medical photography are really very exciting things and are attracting a great reputation around the country. I think they're now one of about four or five schools in the country that more

are accredited.

?Very impressive?

It sure is. And you know, they are a illustration as I hope we are, too, of one of the other advantages of the School of Allied Heatlh being located in a health science center, and that is the constant search for academic excellence, a program in a general academic institution or a program in a junior or community college. is generally designed to accomplish an objective, prepare a rad tech or prepare a med tech or whatever it is. Little effort is devoted to trying to produce a high level of knowledge and competency and a challenge to the individual to go on perhaps into graduate studies. Moreove, the teaching of the technology itself, and our experience often becomes kind of routine and to sort of thing, step A, B, C, D. That's not nearly so true here. Although there are people on my faculty who would prefer it to be that way, but there is a current that sweeps along, and if I bring in to my rehab science program, for example, a couple of new Ph. D.'s who have new ideas and go poking in other area or if I bring into the allied health area people with strong education backgrounds who will go over to physical therapy and say, "We could help you improve your teaching over there," and things like that. Then people tend to get caught in a current and swept along and they begin to talk in terms of research, and they begin to talk in terms of educational improvement It's a climate in which a technology becomes something more than a technology. It becomes an art. It becomes the beginning of education instead of the goal that you reach to get a credential and then go out and do whatever it is you're going to do.

?Where?

You're going to find them in two places. You're going to find them here ~~xx~~ in the academic halls and you're going to find them in the clinical areas in which they are learning to do what, learning to apply what they have been taught here. You're going to see a physical therapist, a therapy student now watching while other people manipulate limbs and help with gate turnign and things like that.

And then as we get on into late April and May, you're going to be able to see those same people doing the manipulating as they move into their own clinical assignments. You're going to see medical technology students across the street for another month looking in microscopes and pouring out of test tubes and working in a ~~pretty~~ sterile climate over there.

And then starting the first of the year, you're going to see them in the laboratories of Parkland Hospital or in Children's Hospital, working side by side with the medical technologists and performing those things.

You're going to see the rehab people doing a clinical rotation at a halfway house someplace, at the pilot school for girls, at the Goodwill Industries, with Texas Rehab Commission, with the board of pardons and paroles, with the crippled children's society, with Caruth and the work, ~~with the~~ retraining work evaluation center. You're going to see them every place, actually learning to do the things that they've been told about here.

The dietitians, God knows where you're going to see them. They're going to be all over.

I thought if you'd like we'd walk quickly through the complex

when you've gotten tired of me talking.

?When see rehab students on clinical rotation?

Right now.

?Nutritionists do?

(Side 2)

Well, our original program here was a postbaccalaureate program, called a dietetic internship that ran for 10 or 12 months. It took people into a nondegreed program with some formal didactic instruction and a good amount of clinical internship directed in a hospital nutrition department.

Two years ago we terminated that dietetic internship program and replaced it with an upper division baccalaureate program, two years junior and senior, in which the students combine didactic instruction with clinical application, not one after the other, but both together. They would, and they do, have lectures in basic science and in applied science areas, but if, for example, they're studying diseases of the circulatory system, their laboratory will be the hospital and their instructors will be going through patient records to identify those patients who are illustrative of some of the dieseases of the circulatory system that dietitians are involved with. in terms of salt-free diets, type 4 diets for low lipids and cholesterol or whatever it might be, bulk diets, and the student on the one hand is lectured, and then instead of going into a simulated laboratory, they go into the real laboratory where the particular people that they've heard about and the particular conditions that they've studied are illustrated and where diets are being written to deal with them.

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?Being trained to work in a hospital environment?

No, they're really not. The hospital environment provides the best laboratory because it concentrates people with problems. But they could just as well go into the community as a nutritional consultant for a series of nursing homes or they could go with a school system as a dietary consultants for the school system or they could go to convalescant homes. They could go just any place there was a need for good therapeutic dietetics information. Go into public health as people prepared to prevent dietary diseases from occurring.

?Dr. Pettenger?

Well, in Dr. Pettenger's field what you eat has a great effect on the drugs that he is giving you and you know that's just an (emerging) science now. I'm not sure that the dietitians are as well prepared in that area as they ought to be. This is one of the reasons that I have misgivings about the really established programs because its pattern has been made, and I'm, I'll be poking at my dietetics people over the next few months about some things that I'm beginning to see now that make me thingk that they're not aware of all the the things that are really important.

My wife just had a bout of acute diverticulitis which is a dreadful thing, and the last words from the doctor were "Until you get over the acute stages, don't have any bulk foods." So I went to a couple of my dietitians and I said, "Give me a list of non-bulk foods." And they weren't too good at it. I may have caught them at a bad moment or something like that, but to me that's the kind of thing that needs to be in therapeutic dietetics.

?Role of research in your school?

We see it slowly but steadily growing and becoming something of considerable importance to us because it doesn't make any difference what program we take--physical therapy, which is a manipulative program, has traditionally been taught by practitioners who are excellent at the mechanics of physical therapy but what about areas of research in physical therapy? What about the cerebral palsy victim who comes to you almost as an infant and who really looks down the road at total invalidism or a family productive life? What kinds of things in physical therapy can be gotten that will get him off in that direction instead of that one?

And in nutrition. All sorts of opportunities for research, and the thing that excites me and encourages me to work in this direction is that fact that it will produce, I think, a more exploring kind of faculty, a faculty that isn't going to be content to keep going with the same technical instruction all the time.

Geronotology. Research is almost the name of the game there.

Rehab science. is one of my good research areas.

?Project for movie?

Yes, I think you have to prepare yourself a little for it because in research, in rehab science, for example, that doesn't involve test tubes and machinery and things like that. You need to talk to Macilere down there who has one of the institutional research grants this year, and you have to talk to Chuck White who has a major research project underway or ready to get underway and sexuality and the aging. you have to find the right people.

who are involved in it, but you have to be mentally prepared for the fact that it's not going to be a bench science type of research.

?Include research in all three schools?

Well, it would be a great service to us, you see, because the orientation of the mentality of the graduate school and the medical school is toward basic research, bench types of research that are going to produce startling scientific discoveries.

We through the vision of Dr. Sprague have just now established a new research grants committee through the school of allied health because the grants research proposals that we were submitting were not comprehended by the biochemists and the physiologists and the microbiologists.

?All kinds of levels of things going on?

There are.

?Why was committee established?

Because our researchers here were submitting proposals for support that a basic scientist just couldn't appreciate. He couldn't understand, didn't consider it research. But you know it is research. It's the kind of research that is readily funded by many agencies and the kind of research that's needed. We have one project here that involves research and development of a computer package or computer program into which can be fed a series of key characteristics of a mental retardate, and the buttons turn down and the wheels whirling and pretty soon coming out of some sort of a pattern form training for that individual, some sort of indication of those areas in which that individual with those characteristics could function effectively, and you

more

know that's a very vital thing. because there's a lot of subjectivity in the evaluation of people with a handicap. If you can apply some sort of standardization to it and at least get yourself up to the starting line with information coming out of the computer, then you can adapt along the way, but this project now has been going on for two or three years, and its involved the collection of enormous amounts of data, and the processing of that data and the creation of a format in which output from the computer will be a useful thing. We looked the other day at a position announcement, and I forget where it came from .....

sp? familiar with McCaren Dahl evaluation system in order to apply. Well, we didn't even know that people outside the school were beginning to pick up on this. There'd been a little publishing on it, but now here's an agency that says, "We're going to be using the McCaren Dayl process, and so if you're going to come work for us in this job, you'd better know how to use it, and what it's all about."

Well, that didn't come from the bench, it didn't come out of test tubes and bottles.

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