

POSITION STATEMENTS (ITEM 1)

03/51

FD # 1

AR.GOV 01 AAMC Series 6: Position Statements Box 1 Folder 1.

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PUBLIC UNDERSTANDING

AND SUPPORT

of

MEDICAL EDUCATION

The Problem and How to Attack it.

March 1951

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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"Public relations is a continuing process by which you endeavor to obtain the confidence and good will of the public, inwardly by self-analysis and correction to the end that the best interests of the public will be served, and outwardly by all means of expression so that the people will understand and appreciate that their welfare is your guiding principle."

--Arthur J. Snider, Science Editor
Chicago Daily News

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T H E P R O B L E M . .

Medical education is under attack. We are accused of restrictive labor practices, of conspiring to limit production for the economic benefit of our profession and against the public interest. The result is public pressure, untempered by understanding and intelligence, which threatens to lower hard-won standards of medical training.

The public today feels very strongly about matters of medical care, and it should be recognized that the public has a greater stake in the quality of medical care than do the educators and physicians themselves. Therefore, it is reasonable to assume that if the public is correctly informed its support of medical education will be positive and vigorous.

The schools of medicine can certainly take the larger share of credit for the enormous advances made in recent years in the quality of medical practice and the growth of medical knowledge. The public too often thinks that these great advances "just happened." This latter attitude is not just restricted to the uninformed laity. Our parent universities and even some members of our own profession cry mightily about this greatly increased cost of medical education without any full realization that the high quality of medical care in this country in 1950 would have been impossible of achievement without the expanded activities, both qualitative and quantitative, in the schools of medicine.

How did we get into this position, a situation which in more than one instance jeopardizes further progress? Who is responsible for the attitude of great concern about golden eggs but increasing criticism and lack of concern about the health of the goose that lays them? It seems clear that the leaders of medical education themselves must shoulder the greatest part of the blame. We freely admit that medical education and the varied operations of the modern medical school represent an extremely complex and unique structure in the educational pattern and yet our efforts to explain our problems have been desultory and inadequate. Some of us have perhaps not fully accepted the philosophy that we exist for the public. Unless the benefits of our activities, both immediate and remote, can be intelligently and vigorously brought to the attention of those who have the obligation to support us, in language which they can understand, we will not move forward and, in fact, may slide backward.

Ours is a problem of positive public information and education. We have nothing to hide. We should not be interested in defensive propaganda. Rather we should concern ourselves with planned, objective, positive programs of public education. Leaders in our medical schools must accept this challenge of public and professional enlightenment as an obligation to be grasped with enthusiasm rather than a chore to be undertaken reluctantly. As Dr. A. C. Ivy has recently said, "The traditional reticence of the medical scientist is responsible for widespread public misunderstanding ---. It is absolutely essential that proper means be made to convey to the public authentic information on medical developments. If we scientists do not make positive provisions for public understanding, we must accept the fact that others who have less knowledge and lower standards will lead public thought. To teach is the duty of those that know. If men, whose business is the accumulation of knowledge, do not accept their educational responsibilities they will have abdicated in favor of ignorance."

The time has long since passed when adequate support for medical education is automatically forthcoming. In order to erase an increasing amount of widespread prejudice and ignorance, leaders in medical education must enthusiastically accept the obligation to inform those for whom they ultimately exist and function, namely, the public.

T H E P L A N

Public understanding is the goal of an honest public relations program. Public understanding of medical education is possible only if you, the medical educator, will pull back the curtain which normally surrounds the activities and policies of the medical school. To pull back the curtain is to make systematic provisions for the dissemination of information to the public.

Intense public interest in health matters affords excellent opportunities to explain the medical school, its activities and problems. These opportunities are to be grasped with enthusiasm by the medical administrator, for public understanding and support may be the greatest single factor in the future of the medical school.

The establishment of a systematic program for the dissemination of information to the public requires decisive action by the dean. It is the dean's responsibility to enunciate a positive policy toward public information and designate the responsibilities of faculty members in carrying out this policy.

A public information officer should be appointed by the dean to provide the continuing initiative and the detailed direction for the program. This person ideally should be a professional journalist, employed full time for this purpose, but it is possible for a member of the teaching or general administrative staff to perform valuable service in this field on a part-time basis. In some cases it will be possible to have a member of the university public relations staff assigned to the medical school.

With the appointment of a public relations officer, definite plans should be laid for a program which is positive and aggressive, systematic and continuous.

Consider your audience.

Your public informational plans will have to take into account the fact that the public which you want to reach is not a single, homogeneous group. Rather there are a number of publics, each with some special interests, each with particular influence on medical education and each accessible through particular channels. Who are these various publics? Following is just a partial list:

- Academic colleagues in related or preparatory institutions
- Civic leaders
- Political leaders
- Members of the health professions
- The farm population
- Organized labor
- Students and students' families

There are many outlets for information.

While the metropolitan newspaper is the classical symbol of public information, it provides only one of the ways in which information can be disseminated, and for some of the groups listed above the newspaper is far from being the best means of communication.

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Informational channels fall in two categories. First are the selective, sharp-shooting channels through which specific groups can be reached most efficiently.

1. Labor papers, farm publications, technical and educational journals, organization publications, racial and special-interest publications.
2. Speakers and organized visits to the medical school by key groups and thought leaders. Contact with organizations.
3. Circulars, leaflets, books and exhibits.

The second group of informational channels are the media of mass communication. They are:

1. General circulation newspapers.
2. Radio and television.
3. General circulation magazines.

Three activities make a complete program.

Routine day-to-day news reporting, occasional feature articles and broadcasts, and work with organized groups add up to a full public information program.

The release of news about the medical school can be routinized so that reports of scientific developments, enrollment information, etc. will automatically be processed for public consumption. An outline of the procedure to be employed is included in the following section of this manual.

In contrast, the development of features for radio broadcasts, magazine articles, etc. requires a custom approach. Each feature article is a special project designed to accomplish a specific purpose, and usually it is aimed at a specific audience.

The question might be asked: What kind of information deserves feature treatment rather than routine news treatment? The rule-of-thumb answer is that news items can convey only one single point at a time. Feature articles and broadcasts, on the other hand, can bring together related information and present a broader picture. Obviously the feature article is the device for developing public understanding of complex matters.

The third element of the public information program, which is work with organized groups, is the most sharply aimed. The purpose is to communicate with groups as you would with individuals on the basis of their interests, their questions, and their relationship to your work.

The most obvious and most important thing to do is to make speakers available for meetings of Kiwanis Clubs, PTA meetings, etc. A good speaker can give a more vivid and more interesting picture of the medical school, its policies, operations, and problems than could be given by written material. Next best are articles for organization publications and, when the occasion justifies, leaflets, circulars, etc. Also possible in this field are exhibits, demonstrations, and "open house" visits for key groups and individuals.

Gaining acceptance for medical school information.

You will find that acceptance of medical school news, speakers, and other informational presentations will grow rather than reaching a saturation point. The more public understanding you develop, the more public interest results.

Like all teaching and all communication, your program of public education will be effective in direct proportion to the vividness of your presentations. This is not a problem of subtle artistry but rather a matter of plain talk in concrete terms. A convenient simile or analogy is nearly always useful, for it gives you the chance to explain the complexities of medical education in terms of the every day experiences of your audience.

T H E M E C H A N I C S

There is a wide discrepancy in most cases between the attitude of the medical school staff and the news writer toward medical college news. Medical college teachers, administrators and research workers feel that news releases from the school must be first of all accurate, that they must not raise false hopes of quick cure, and that they must not aggrandize any particular individual.

News writers, on the other hand, labor under the necessity of having to set forth something new, something interesting and something "just off the fire." To be really news, to a

newsman, the event must have just happened, and getting the report out quickly is as important as getting it out accurately. They are aware of the oft-quoted aphorism "today's masterpiece becomes tomorrow's fish wrapper" and they are, therefore, sometimes loath to check and recheck for accuracy's sake when by so doing they lose a time advantage. To many news men too, "names are news," and reports without names have little or no appeal.

Fortunately, with cooperation between the faculty man and the news writer it is possible for medical news to be accurate and still of great public interest.

In overcoming traditional reticence medical college administrators will find the following recent revision of the American Medical Association's principles of ethics (section on educational information under Chapter I) of interest.

"Many people literate and well educated do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable. The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by its publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing."

Steps in a publicity program.

1. Appoint a Public Information Officer full-time or part-time, either from the teaching staff or from the fields of journalism, publications, or public relations.
2. Channel all press releases through this Public Information Officer.
3. Establish rapport between the school's Public Information Officer.
4. Initiate the following chain of events whenever a staff member is ready to publish a scientific paper.
 - a. A copy of the manuscript is sent to the Public Information Officer with name of journal of publication and information regarding scheduled date of publication.

- b. The Public Information Officer prepares a news release, checks it with the author of the article and dates it for simultaneous release with the article in the scientific journal. (Scientific information never should be released to the public before it is released to scientists.)
- c. If the local press desires a more extensive coverage, the Public Information Officer brings the news writer to the author for an interview. Following the interview every desired assistance is given the news writer in completing his article.

News writers who can accurately state the scientific findings of a research study in language understandable and interesting to the public can be found. It is the duty of the Public Information Officer to find such persons, work with and assist them and indoctrinate them with the principles so important to the medical worker. Basic among these principles would be: Recognition of the fact that the present research is based upon the work of many others, therefore, undue credit to the author is unjustified and harmful to his professional standing; avoidance of more sweeping claims than the modest results of the research justify; avoidance of creating false hopes of quick cures.

The sources of news items.

Teaching hospitals are a rich source of news releases. Whenever possible these releases should be so worded that the relationship of the hospital to the medical school is stated.

Items of information about the school will have particular news value and will receive more generous treatment by the press at certain times and it is suggested that special consideration be given to news releases on the following occasions:

1. At opening of college in the fall.
 - a. Registration numbers and increase of any over that of last year or ten years ago
 - b. New faculty members beginning work
 - c. Students from abroad
 - d. New quarters or new apparatus being put into use
 - e. Any notable changes in curriculum
 - f. Negro students enrolled

2. At the time of publication of faculty research, faculty textbooks, new college catalog, etc.
3. At graduation day in June
 - a. interesting facts about members of graduating class and what they intend to do
 - b. Honors and prizes
 - c. Retirements from the faculty
4. At time of alumni reunion
 - a. Interesting facts about returning alumni
 - b. Recent changes in school and faculty
5. At the time of deaths and retirements from faculty
6. Upon the receipt of gifts and grants
7. Celebration of anniversaries -- Founders Day, etc.
8. Opening of new building or addition
9. At time an alumnus or faculty member receives some special mark of recognition.

F A C T S

What are the common misconceptions regarding medical education and what are the facts?

On the following pages you will find an analysis of these misconceptions. It is intended that these facts will be continuously kept up to date and expanded by dated releases from the office of the Association. These releases will be stamp-marked on their right upper corner "For the Public Information File."

A commonly held false belief:

That only one student out of ten applying for admission to medical college actually gains admission.

The actual facts:

In the Fall of 1949, 24,434 students made 88,363 applications to our seventy-nine medical schools for admission to the entering class. 7,054 achieved enrollment. Thus, approximately one out of three and one-half applying for admission actually gained admission.

The average applicant applied to three and six-tenths different schools. Some applied to over thirty schools. There was great variation among the medical schools in regard to the number of applications received. The ratio of applications to admissions ranged as high as 40 to 1 in one school to as low as 1.7 to 1 in another.

In the Fall of 1950, 22,279 students made 81,638 applications for admission. 7,253 achieved enrollment. Approximately one out of three applying for admission gained admission. The average applicant applied to three medical schools.

Through the years previous to World War II never less than one out of two applicants was accepted. With the influx of students in higher education under the "G.I. Bill of Rights" the liberal arts colleges have been able to expand their enrollments more rapidly than have the medical colleges.

A commonly held false belief:

That only students with a college average of A have a chance of being admitted to the medical schools of this country.

The actual facts:

College marks are only one of a number of things taken into consideration by a medical college admission committee in selecting students. In addition to the average grade, the grades in certain subjects are sometimes given special attention. The score on the Medical College Admission Test may be an important element especially if it does not confirm other evidence. The personality of the student, and his basic adjustment are also significant factors. Some schools require a physical examination.

In a recent study*, some 54 medical schools reported that they had admitted students to the freshman class of 1949-50 whose grade point average was less than a B-. These students were somewhat under ten percent of the total admitted group.

While these figures should make it clear that the belief that only straight A students are admitted is incorrect, it should not obscure the fact that high academic grades are the usual indication of a superior prospect for medical school. Low grades must be offset by a high score on the Medical College Admission Test or other evidences of a superior student who will succeed in medical school.

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States & Canada" - Journal of American Medical Association - September 9, 1950.

A commonly held false belief:

That persons of great influence are frequently able to bring about the admission of favored candidates to certain medical schools.

The actual facts:

The selection of students for the entering class is carried out in almost every medical school of the country by an admissions committee consisting of three or more professors. Selection is by vote of the members of the committee for the most promising of the candidates. Justification for each selection is available in the individual folder of each student kept in the student record file of the school. Among those data are usually the following: a transcript of college record showing the marks in the individual courses taken, the results of the Medical College Admission Test, letter of evaluation or recommendation from college teachers or others well acquainted with the candidate, the student's application forms (including data on family background, interests, hobbies, extra-curricular activities, results of an interview).

With such a plan for selection of students it is quite unlikely that persons of influence could do much more than procure a hearing for a favored candidate.

A commonly held false belief:

That Negroes are admitted only to two United States medical colleges, Howard and Meharry.

The actual facts:

An ever greater majority of the 79 medical schools of the country admit Negroes. In 1949-50, of the 25,103 medical students 647 were Negroes. Of these 268 were registered at Howard 245 at Meharry and 134 at 40 other medical schools. There were 180 freshmen, 166 sophomores, 149 juniors and 152 seniors.* Though medical educators do not accept the principle that the medical needs of the Negro population must be met entirely by Negro physicians, or that the Negro physician should limit his practice to Negroes, they are nevertheless agreed that there is a real need for more Negro physicians. Admissions committees in many of the medical colleges are attempting to increase their enrollment of Negro students but they feel it would be a mistake to drop admission standards to meet this need even though it be somewhat urgent.

It is obvious that until the elementary, secondary and college educational opportunities for Negroes are improved, medical colleges will continue to find the supply of properly qualified Negro applicants limited.

At a conference sponsored by the Rockefeller Foundation in Atlanta, Georgia in April of 1948, means were discussed for selecting promising Negro candidates, for providing needed scholarships and for strengthening certain colleges and encouraging them to give special attention to the preparing of Negro students for admission to medical college.

It is estimated that the Negro population makes up approximately 10 per cent of our total population. In 1949, the 647 Negro medical students enrolled made up 2.6 per cent of total medical college enrollment.

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of the American Medical Association - September 9, 1950.

A commonly held false belief:

That only a few of the United States medical colleges admit women.

The actual facts:

All the United States medical schools, except Dartmouth and Jefferson, admit women students. Of the 25,103 students in the four classes of our United States medical schools in the year 1949-50, 1806 or 7.2 per cent were women.*

The Woman's Medical College of Philadelphia admits only women. It had 176 students enrolled in 1949-50.

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of the American Medical Association - September 9, 1950.

A commonly held false belief:

That it is futile to train women in medicine because the majority marry and never practice medicine.

The actual facts:

Lowther and Downes studied the careers of 1,240 women who, in the twenty years prior to 1940, had graduated from the medical schools of Columbia, Cornell, Johns Hopkins, New York University, Yale, the University of Pennsylvania and Woman's Medical College of Pennsylvania. They found that 82 per cent of the married women remain in full-time medical practice and 90 per cent of them engage in some form of medical activity. Twenty-four per cent of this group were found to have taken enough advanced training to qualify as medical specialists and an additional eight per cent combined partial specialization with general practice. The specialties most frequently chosen by women were pediatrics, psychiatry, internal medicine, and obstetrics and gynecology.

A commonly held false belief:

That medical school admission requirements are so exacting and special that they determine the curriculum the student must follow in his college course and prevent him from obtaining a liberal education.

The actual facts:

The minimum requirements which the members of the Association of American Medical Colleges have agreed to for their entering students are: not less than two full academic years, which shall include English, theoretical and practical courses, in physics and biology and general and organic chemistry. Certain medical schools have additional special requirements. The requirements for each of the medical schools in the United States is given in detail in a booklet on Admission Requirements of American Medical Colleges which is published by the Association of American Medical Colleges. A study of the requirements will indicate that if a student wishes to apply to the usual three or four medical schools he can take all of the necessary required courses and still have more than two-thirds of his classroom hours available for meeting the other requirements of a liberal education, especially from the social sciences and the humanities.

For many years experienced and far-sighted medical educators have decried the existence of anything and everything savoring of "pre-medical." College preparation for the medical field should not be professional in character, but should be devoted to the objective of providing as broad a cultural education as the particular institution can give.

A commonly held false belief:

That medical schools are not expanding their facilities on the assumption that increased numbers of physicians are not needed.

The actual facts:

In the past five years two completely new medical schools (Southwestern in Dallas, and the University of Washington in Seattle) have been established; two two-year schools have expanded to four-year schools (University of Alabama in Birmingham, University of Utah in Salt Lake City); one older college has been approved and admitted to the Association of American Medical Colleges membership (Chicago Medical School); the State University of New York has taken over and expanded two medical schools (Syracuse and Long Island).

Extensive medical school building programs were completed or gotten under way in 1950 at the following medical schools: Alabama, Albany, California at San Francisco, Cincinnati, Emory, Minnesota, North Carolina, North Dakota, Pennsylvania, Pittsburgh, Rochester, and the University of Washington in Seattle.*

Construction of new or additional clinical facilities were made in 1950 at: University of California, Colorado, Illinois, Indiana, Maryland, Michigan, New York University, Ohio State, Oklahoma, Oregon, Pennsylvania, Pittsburgh, Vermont, Washington University at St. Louis.*

Money is appropriated and extensive construction planned at: Arkansas, California at Los Angeles, Colorado, George Washington, Indiana, Mississippi, Oregon, Pittsburgh, South Carolina, South Dakota, Southern California, Stritch, Temple, Tulane, Virginia, Woman's Medical.*

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of the American Medical Association, September 9, 1950.

A commonly held false belief:

That the organized medical profession controls the accrediting of medical colleges through the American Medical Association's Council on Medical Education and Hospitals, and that the medical college teachers and deans have nothing to do with it.

The actual facts:

All inspections of medical colleges are done jointly by representatives appointed by the American Medical Association's Council on Medical Education and Hospitals and the Association of American Medical Colleges (consisting of medical college teachers and deans). Upon the basis of the facts accumulated by these joint inspection teams, the American Medical Association's Council votes approval or disapproval, and the Association of American Medical Colleges independently votes acceptance or rejection for membership.

At present all medical colleges in the United States are approved by the American Medical Association's Council; one has not yet been accepted into membership in the Association of American Medical Colleges.

A commonly held false belief:

That the organized medical profession is limiting the numbers of new students and the development of new schools as a part of a program of limiting the number of practicing physicians.

The actual facts:

Both the American Medical Association's Council on Medical Education and Hospitals and the Association of American Medical Colleges are giving assistance and encouragement to the development of new medical schools in every area where the interest, need, financial backing, and population density justify such a venture (examples of such are in the states of New Jersey, Florida and Washington).

Both the American Medical Association's Council and the Association of American Medical Colleges are of the opinion that one qualified instructor for every twenty-five students will be required in each of the chief preclinical subjects if instruction is to be maintained at a high level. If that ratio is maintained and the size of the laboratories permits, no limits are set by either accrediting agency as to the size of classes. The registration in the seventy-nine medical schools in 1949-1950 varied from 656 at the University of Illinois to 162 at the University of Vermont. Over 300 more freshmen were enrolled in 1950 than in 1949 in the existing medical schools.

Increases in the numbers of medical students can only be made as rapidly as increased staff can be recruited and increased laboratory and clinical facilities provided. The medical schools of the United States reported that up to June 1950 they had been unable to fill vacancies for 240 full-time teachers in the preclinical departments, 201 full-time teachers in the clinical departments.* The effort on the part of every one concerned is definitely to increase the numbers of medical students not arbitrarily limit them.

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of the American Medical Association - September 9, 1950.

A commonly held false belief:

That medical schools after being inspected are rated on an A, B, C and D scale.

The actual facts:

In the survey conducted by Abraham Flexner for the Carnegie Foundation for the Advancement of Teaching (published in 1910) the 131 medical schools then existing in the United States were listed on an A, B, C, D rating scale.

More than 30 low grade medical schools had either closed their doors or merged with stronger institutions in the period 1906-1910. Between 1910 and 1915, 35 more of the weaker schools closed or merged; 11 more followed suit between 1915 and 1920.

In recent years schools have not been rated on a scale but listed as approved or not approved by the Council on Medical Education and Hospitals of the American Medical Association, as in membership or not in membership in the Association of American Medical Colleges. All medical schools in the United States are approved at this time by the American Medical Association Council and all but one are members of the Association of American Medical Colleges.

A commonly held false belief:

That since World War I the population of the United States has increased much faster than has the number of physicians.

The actual facts:

In 1920 we had 144,977 physicians for a population of 105,710,620 persons.

In 1950 we have 201,277 physicians in the United States for an estimated 153,000,000 persons.*

The gain in population for the thirty years is about 45 per cent; the gain in number of physicians for the thirty years is about 39 per cent.

In 1920 we had one physician for every 729 persons; in 1950 we have one better trained physician to every 760 persons.

Crucial to an understanding of this problem is the fact that the physician of today

- a. is much better trained than the physician of 1920,
- b. has a great deal more assistance from nurses, technicians and other auxiliary personnel and equipment.
- c. sees many more of his patients in hospitals and is required to spend a much smaller part of his time in travel, and

The physician's availability must be measured by time rather than distance. Many persons in rural areas claiming lack of medical care are closer to it in terms of time than are their urban neighbors.

* American Medical Directory - Frank V. Cargill, Editor - American Medical Association, Chicago, 1950.

A commonly held false belief:

That every state in the country should have its own medical school to prepare physicians for practice in that state.

The actual facts:

Thirty-one of our states now own medical schools. Virginia, New York, Texas and California each own two medical schools. Many of the states that do not now have a medical school would find it very difficult to establish a good one; first, because it would be difficult to attract and keep a staff of high caliber in a sparsely settled area with limited hospital facilities; second, because the clinical teaching of the last two years of medicine demands teaching hospitals and dispensaries affordable only in larger population centers; and thirdly, because of costs states with small, widely scattered populations frequently find it cheaper to send their students to medical schools already established in large population centers in neighboring states, supplementing the non-resident tuition which the student pays with a sum (approximately \$1,500 per student) sufficient to reimburse the neighboring state for full costs.

Just because a physician gets his medical training in a medical school of a state does not by any means guarantee that he will, therefore, decide to set up practice in that state. Rarely more than fifty per cent of the alumni of a medical school return after their internship to establish practice in the state where their medical school is located.

A commonly held false belief:

That it is as easy to expand the enrollment of a medical college as to expand the enrollment of a liberal arts college.

The actual facts:

Since much of the teaching in a liberal arts college is done by the use of the lecture method, increasing the size of the class entails very few difficulties.

Comparatively little of the medical college teaching is done by the lecture method. The six basic sciences of the first two years of medicine are taught largely in the laboratory and require a certain irreducible amount of laboratory space, equipment and supervisory staff time for each student. The clinical teaching of the third year of medicine is largely in the hospital and requires approximately eight teaching beds for each student in the class in order to provide each student with the needed average of three new cases a week. The clinical teaching of the fourth year of medicine is largely in the out-patient clinic which should be large enough to provide each student in the class with three new cases a day.

Increasing the size of the entering class in medicine requires then, in most instances, expanding the laboratories and staff, increasing the teaching beds, and enlarging the out-patient clinic. All of these changes take time, a considerable capital outlay and an increased operating cost. Many schools cannot expand because of the limited amount of clinical material available for teaching purposes in their community.

A commonly held false belief:

That the big reduction in the number of medical schools that took place between 1906 and 1920 was due to the desire to reduce the output of physicians.

The actual facts:

A large majority of the 162 medical schools in existence in this country in 1906 were proprietary schools operated for the profit of individuals and unaffiliated with any university. Some of these schools were little better than "diploma mills." Only a few came up to the standards being maintained at the time by the better medical schools of the United Kingdom, Germany and Austria.

Inspection and classification of the schools on an ABCD basis made it possible for students to identify the weaker schools and shun them. As the result of this classification 77 of the weaker schools either closed or merged between 1906 and 1920. This resulted in reducing the medical student body from 25,204 in 1906 to 13,798 in 1920. Gradually, however, the strong surviving schools increased the size of their classes at the same time raising their standards.

Medical education has come a long way since 1910. The quality and thoroughness of the medical training being offered in our schools today is of an entirely different order from that offered in the days before 1910 and is second to none in the world.

A commonly held false belief:

That the costs of operating a medical school are all legitimately chargeable to educating medical students for the M.D. degree.

The actual facts:

It is not unusual for a medical school with 60 medical students in each of its classes to also provide instruction for 40 to 60 nurses, for 50 to 75 graduate students, 15 to 30 technicians, 15 to 30 interns, 30 to 50 residents. Many medical school departments also provide instruction for liberal arts college students in such fields as physiology, bacteriology and biochemistry.

A large number of medical college teachers devote from one-third to one-half of their time to research.

In the medical school's teaching hospital and out-patient clinic the medical school staff commonly provides medical service free or nearly free to several thousand needy persons each year.

A commonly held false belief:

That medical schools are able to support themselves on the tuition provided by their students.

The actual facts:

The average tuition fee for 1950-1951 in our medical schools is \$554 (it was \$378 in 1939-1940). The tuition fees at present provide only about twenty-two and one-half per cent of the costs of operating the medical schools.*

The budgets of the two-year and four-year medical schools of the United States, 1950-1951, total approximately \$67,500,000; receipts from tuition during that year total \$15,200,000.*

It should be emphasized, however, that much of the cost of operating a medical school should in all fairness be charged to (a) the training of dentists, technicians, nurses and others; (b) post-graduate education; (c) research, and (d) the medical care of the community's indigent ill.

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of American Medical Association - September 9, 1950.

A commonly held false belief:

That medical schools today are not seriously attempting to prepare students for the general practice of medicine.

The actual facts:

The medical schools recognize that our system of medical care requires that a reasonable proportion of physicians continue to do general practice.

Thirteen of our medical schools have organized preceptorships varying from one week to three months in length but designed to stimulate interest in a career in general practice. Fifteen schools are sponsoring in their affiliated hospitals internships specifically designed for prospective general practitioners. Twelve schools are sponsoring residencies for prospective general practitioners.*

Many of the medical schools are developing their post-graduate courses around the needs of the general practitioner.

Of the 201,277 United States physicians listed in the American Medical Association's 1950 Directory, 72,550 were doing general practice only; 22,976 were doing general practice with some attention to a speciality; 54,891 were limiting themselves entirely to a specialty; 12,536 were in Federal Government service; 3,737 were doing administrative, editorial or executive work; 24,887 were acting as interns, residents or physicians in hospitals only; 9,700 had retired or transferred to fields other than medicine. Forty-seven per cent of our physicians do general practice.

Questionnaire studies of 31 classes in 19 medical schools in 1949 revealed that 47.3 per cent of the students intended to enter general practice, 31.1 per cent planned to specialize, 21.6 per cent were undecided.*

* Donald G. Anderson and Anne Tipner - "Medical Education in the United States and Canada" - Journal of American Medical Association - September 9, 1950.

A commonly held false belief:

That only about fifty per cent of the students who enter the study of medicine complete it and receive their M.D. degree.

The actual facts:

The average entering class over the past twenty years has numbered 6,241. The average graduating class has numbered 5,230.

The average loss from each class has been 1,011. This gives us an attrition rate through the four years of medical college of 16.3% rather than 50%.

Many of those who withdraw do so voluntarily, because of health, change of interest, or family or financial reasons rather than failure in studies.