June 8, 1976 Response of the AAMC to the United States General Accounting Office in the Matter of a Study Dealing with Geographic and Specialty Distribution

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RECEIVED - - MHL
JUN 8 1976

RESPONSE OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES TO THE UNITED STATES GENERAL ACCOUNTING OFFICE IN THE MATTER OF A STUDY DEALING WITH THE GEOGRAPHIC AND SPECIALTY DISTRIBUTION OF PHYSICIANS

The Association of American Medical Colleges (AAMC) is pleased to respond to the questions posed by the U.S. General Accounting Office related to its study of the geographic and specialty distribution of physicians. The Association and its constituent 114 academic medical centers, 400 teaching hospitals, and 60 academic societies are the principal institutions and organizations responsible for the education of physicians from the time of their selection to enter medical school until they leave their formal training and assume professional roles in the health care system.

HISTORICAL PERSPECTIVE

AAMC and Primary Care

The AAMC is now and for many years has been vitally concerned with educating physicians who will provide the full range of medical services expected by this Nation's citizens. In 1925, the AAMC organized the Commission on Medical Education, which was directed by Dr. Willard C. Rappleye. The Commission's Report, published in 1932, called attention to the trend toward rural-urban migration of physicians and the fragmentation of care by specialization. The need for educating physicians who would fulfill the role of providing continuing and comprehensive care was recognized in the Commission Report.[1]

In 1952 an AAMC Conference on Preventive Medicine called for physicians to provide comprehensive, continuing care based on patients as individuals within the context of their physical and social environment.[2]

"Planning for Medical Progress Through Education" published in 1965 is a major AAMC report. The present structure and operation of the Association is based upon the recommendations contained in this report. Among those recommendations was "that particular effort be made to provide leadership and aid in the development of improved approaches to family practice."[3] Subsequent to this report, an AAMC committee (Committee on Medical Schools and the AAMC in Relation to Training for Family Practice) chaired by Dr. Edmund Pellegrino expanded on this recommendation and in 1968 published a report. The first recommendation of that report was, "There is a major national need for better provision of comprehensive, personal primary or family medical care."[4]

In 1973 the AAMC surveyed the academic medical centers to determine how primary care education was evolving in the institutions.*[5]

In October of 1974 an AAMC sponsored Institute on Primary Care brought together representatives from the medical schools, specialty societies and teaching hospitals. The two and one-half day program explored a variety of approaches to educate and train students who will develop professional careers as generalist-specialists, capable of providing high-quality, comprehensive care with an emphasis upon the continuity of their relationship with patients.[6] Following this Institute, AAMC held six regional workshops to facilitate the extension of knowledge about effective approaches among the institutions and their faculties. A final report on the Institute and workshops was published in 1975.[7]

*This survey is now in the process of being repeated and will be completed during the late summer or early fall of 1976.

During the fifty years from 1925 to 1975, the AAMC has repeatedly sought to ensure that physicians were educated to provide comprehensive, continuing care. In recent years this had led to direct assistance to the academic medical centers through the workshops described above, and presently, through a program to improve the provision of ambulatory patient care services in the teaching setting. This AAMC program is currently in progress and involves 11 centers.

The Continuum of Medical Education,
Institutional Responsibility for Graduate Medical Education, and
A National Agency for Graduate Medical Education Quality Control

During the last decade, three major developments have occurred which will significantly improve the responsiveness of the medical education system to public need in the future. These are: 1) The acceptance by medical educators of the concept of the continuum of medical education, 2) the development of institutional responsibility for graduate medical education, and 3) the development of a national umbrella organization responsible for setting policies and accrediting graduate medical education.

An important conceptual transition has been evolving in American medical education since the early 1960s, which is germane to the questions raised by the General Accounting Office. In the report, "Planning for Medical Progress Through Education," Dr. Lowell Coggeshall stated, "Medical Education should in the future be planned and provided as a continuum -- a continuous process with all elements carefully integrated under coordinated leadership." This emphasis on linking medical education prior to awarding the M.D. degree to subsequent graduate training is wholeheartedly supported by the AAMC.

Accomplishing this linkage requires that graduate education becomes the institutional responsibility of the academic medical centers. In 1968 the Association published the proceedings of a national conference sponsored by its Council of Academic Societies on "The Role of the University in Graduate Medical Education."[8] The conference report recommended that the universities encourage their faculties to assume the same sort of responsibility for graduate medical education that they had for undergraduate medical education. This recommendation was, in 1971, developed into an official AAMC statement.[9] (The Coordinating Council on Medical Education adopted a similar statement in 1974.) In 1973, "Guidelines for Institutions Seeking to Assume Institutional Responsibility for Graduate Medical Education" were published.[10]

The 1968 Council of Academic Societies conference reaffirmed and urged implementation of a recommendation made in the 1965 Coggeshall report that a national commission responsible for overseeing the quality of graduate medical education be established by the private sector. From 1968 until 1972, the Association made various attempts to achieve this goal. In 1972 agreement was finally reached between the AAMC and four other major medical organizations (American Board of Medical Specialties, American Hospital Association, American Medical Association and Council of Medical Specialty Societies) to establish the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education, in which each organizations is a participating member.

The Liaison Committee on Graduate Medical Education now has the responsibility and authority to accredit graduate programs and, since becoming fully functional in 1975, has made considerable improvement in the policies and procedures for quality control in graduate programs. The Coordinating Council on Medical Education has provided a forum for discussion of major issues and the adoption of policies relating to specialty distribution and geographic distribution of physicians.

The AAMC has consistently been the strongest advocate for the promotion of these trends toward integrating and improving graduate medical education. It cannot be too heavily stressed that in the future graduate medical education will, because of these developments, be of higher quality, more appropriate to students' needs, and more capable of responding to modifications in specialty distribution perceived as necessary to provide optimal medical services to the country.

RESPONSE TO SPECIFIC QUESTIONS POSED BY THE GENERAL ACCOUNTING OFFICE

1) Does your organization believe that more primary care physicians (general practitioners, family practitioners, obstetricians-gynecologists, internists, pediatricians) and fewer other specialists are needed in the United States today?

In 1973 the Graduate Medical Education Committee of the AAMC recommended that 50% of graduating medical students enter training programs in the primary care specialties. Subsequently, the Asso-

ciation approved the report on physician distribution prepared by the Coordinating Council on Medical Education, which also recommended that 50% of graduating U.S. students should be primary care specialists. This target, of having 50% of U.S. graduates in the four primary care specialties and the remaining 50% in the remaining 19 specialties, appears a reasonable goal at this time; but the adequacy of this estimate of need should be re-examined periodically.

Recent data reported by J. S. Graettinger, Executive Director of the National Intern and Resident Matching Program,[11] are of great importance in focusing attention on what will be needed in the future to accomplish this goal. (See Table I)

Table I

U.S. STUDENTS MATCHED THROUGH THE NIRMP INTO THEIR FIRST GRADUATE MEDICAL EDUCATION YEAR IN 1976

	No.	(%)
Family Practice	1,345	(13%)
Internal Medicine	4,071	(38%)
Pediatrics	1,107	(10%)
Ob-Gyn	575	(5%)
Primary Care Total	7,099	(66%)
Flexible Programs	988	(9%)
Surgery & Surgical Specialties	1,814	(17%)
All Other*	882	(8%)
Total Matched	10,783	(100%)

(*Pathology, Radiology, Psychiatry, Medical Specialties)

These data demonstrate that students in U.S. medical schools are overwhelmingly responding to the national call for more primary care physicians. The reasons for this responsiveness are multiple, and doubtlessly complex. However, 1976 graduates and medical students now in school are being provided options to learn about the opportunities and challenges in primary care to a far greater degree than were their counterparts a decade ago. In June of 1965, 67 schools reported their efforts to provide such educational opportunities.[12] Through federally-funded special projects, financing from state sources, and from private foundations, the vast majority of schools have modified their programs to place an emphasis on primary care. These efforts apparently have paid off. With 66% of graduating students in primary care specialties programs for their first year, and another 9% in flexible rotating programs, 75% of the class of 1976 could potentially develop careers as primary care physicians. The challenge now is to make sure that graduate education for primary care is both available and of high quality.

In November of 1975, 50 chairmen of medicine reported that they were attempting to develop graduate programs in internal medicine which would attract and train internists to remain generalists. Of these, 34 reported the principal deterrent to program development was lack of funding, and 28 reported the need for improved ambulatory care facilities in their institutions. Despite financial and facilities strictures, training opportunities for primary care positions increased by 1,442 (+13%) from 1974 to 1976, while

the number of first-year surgical training positions actually decreased by 35 (-1.5%).[11] However, if full advantage is to be taken of the movement by medical students toward primary care, the move to expand and improve graduate medical education in the primary care specialties must be accelerated.

2) Does your organization believe that the matter of obtaining an appropriate mix among specialty physicians can best be achieved by free market forces or is this a matter needing more concerted action?

The response to Question 1 which reports the trends toward primary care career development among medical students illustrates that students and their institutions respond to what can be called "market forces." In the introductory section on "Historical Perspectives," the Association's repeated emphases on the need for a balanced distribution of physician specialists over a 50 year period were documented. However, only since 1970 have resources been available to the academic medical centers to develop programs emphasizing primary care. In fact, market forces imposed on the academic centers prior to 1970 were predominantly those which evolved from the emphasis on improving health care through biomedical research, which was the national policy implemented by the Federal Government through the National Institutes of Health after World War II. At that time there was a strong public perception that expanding the scientific base for medicine and applying that expanded base to clinical problems was of first priority.

Resources were provided to expand the research capabilities of the institutions, and the institutions responded with the development of sophisticated basic and clinical science faculties and the provision of educational programs which were directed toward educating a generation of physicians who could apply the fruits of scientific investigation to curing diseases.

Even though the resources for primary care program development have been relatively meager, the institutions, their faculties, and their students have responded to the present public perception of a need for a compensating balance of general physicians capable of providing comprehensive, continuing care.

Having achieved this response it is necessary to look forward toward modifying market forces to solidify the gains already made. One modification is improved support for graduate medical education in the ambulatory setting. It is in this setting that a major portion of the education of primary care physicians should be conducted. Reimbursement policies for patient care in ambulatory teaching settings have traditionally provided inadequate support. The Institute of Medicine study on Medicare-Medicaid reimbursement recommends changes in reimbursement policies for care in the ambulatory teaching setting to make viable such training sites.[13] The AAMC strongly endorses this recommendation.

Another modification which must be considered is changing fee schedules for practicing physicians so that comprehensive, continuing care is rewarded more equitably than at present. Current fee schedules

appear to place the greatest reward on short-term, technical interventions in acute disease states. Comprehensive, continuing care, which requires provision of less dramatic services by physicians and other members of the health care team, will not be achieved unless market forces provide the appropriate incentives.

Achievement of a particular distribution of physicians by "more concerted action" implies that this be accomplished by the imposition of regulations which might run counter to the market forces impinging on the system. It appears doubtful that regulatory policies considerable divergent from trends established by market forces could be successfully imposed. On the other hand, clear and coherent national policies arrived at through consensus and implemented through changes in incentives will be essential to accomplish modification of specialty distribution in the future.

3) *Does your organization believe that the matter of obtaining a more adequate geographic distribution of physicians can best be achieved by free market forces or is this a matter needing more concerted action? In that regard, what role, if any, does your organization play in helping to control the geographic distribution of physicians for the United States?*

The selection of a geographic area by any particular physician results from the interplay of a complex group of social, cultural, and economic forces. In general, the pattern of physician location is similar to the pattern of location of other segments of society. This is appropriate. However, there are geographic areas where the

special needs of populations for medical services as opposed to other services must be specifically addressed. These are particularly in the remote rural and the inner-city regions of the country. The Association strongly supports the further development of the National Health Service Corps as a means of providing rapid relief to geographic areas with inadequate medical services. The Association recommends that the National Health Service Corps program be expanded and improved. The Corps could serve as a model for medical practice in underserved areas and thus encourage the permanent settlement of physicians and other health professionals in these sites. However, as emphasized in the Institute of Medicine report,[13] it is also necessary that the reimbursement policies of Medicare-Medicaid and private third-party carriers which may be disincentives to the permanent establishment of careers by physicians in these areas be examined and corrected.

The Association is firmly opposed to mandatory requirements that a particular group of physicians (those seeking to enter medical education or now in the process of completing their education) be required to serve in shortage areas as a condition of their being educated. The Association believes that voluntary enlistment in the National Health Service Corps will more than fulfill the need for manpower for this program.

The academic medical centers have been the major contributors to innovative efforts to provide incentives for developing physicians to consider practicing in shortage areas. Forty-four centers are

engaged in the development of Area Health Education Centers. (Table II)

Table II

MEDICAL SCHOOLS ENGAGED IN
AREA HEALTH EDUCATION CENTER DEVELOPMENT

1. University of Alabama School of Medicine
2. Meharry Medical College School of Medicine
3. University of Arkansas School of Medicine
4. University of California, Los Angeles, School of Medicine
5. University of California, San Francisco, School of Medicine
6. University of California, San Diego, School of Medicine
7. Stanford University School of Medicine
8. University of California, Davis, School of Medicine
9. University of California, Irvine, College of Medicine
10. Loma Linda University School of Medicine
11. University of Southern California School of Medicine
12. University of Hawaii School of Medicine
13. University of Illinois College of Medicine
14. Indiana University School of Medicine
15. University of Kentucky College of Medicine
16. University of Louisville School of Medicine
17. Tufts University School of Medicine
18. Johns Hopkins University School of Medicine
19. University of Maryland School of Medicine
20. University of Michigan Medical School
21. Michigan State University College of Human Medicine
22. University of Minnesota Medical School, Minneapolis
23. University of Missouri, Columbia, School of Medicine
24. University of Missouri, Kansas City, School of Medicine
25. University of Nebraska College of Medicine
26. University of New Mexico School of Medicine
27. University of Rochester School of Medicine and Dentistry
28. SUNY At Stony Brook Health Sciences Center School of Medicine
29. University of North Carolina School of Medicine
30. University of North Dakota School of Medicine
31. University of Cincinnati College of Medicine
32. University of Pittsburgh School of Medicine
33. Hahnemann Medical College of Philadelphia
34. University of Pennsylvania School of Medicine
35. Medical College of Pennsylvania
36. Pennsylvania State University College of Medicine
37. Brown University Program in Medicine
38. Medical University of South Carolina College of Medicine
39. University of Tennessee College of Medicine
40. Baylor College of Medicine
41. University of Texas Health Science Center at Dallas Southwestern Medical School
42. University of Texas Medical Branch at Galveston Medical School
43. University of Washington School of Medicine
44. West Virginia University School of Medicine

4) Does your organization have a role or responsibility in determining the appropriate mix of specialty physicians for the United States?

The constituent institutions and organizations of the AAMC are the principal educators of physicians in the United States. From the time of their selection for admission to medical school until the completion of their formal residency training, U.S. medical students are enrolled in educational programs which are principally provided by AAMC constituents.

The medical school faculties select those to be admitted to medical school. Through the admissions process, faculties attempt to select individuals who have the intellectual ability to pursue the study of medicine, and the background and personal qualities necessary to meet the need of the public for a variety of medical services. During the past three years the Association has been revising and improving the Medical College Admission Test (MCAT). This test, which is taken by essentially all medical school applicants, was initiated in its present form in 1952. Its principal purpose was to identify students who might not be able to complete the medical course work. The Association has spent nearly one million dollars since 1972 to produce a totally new exam which will more selectively identify student characteristics. The new MCAT will be introduced in the Spring of 1977. Presently, the AAMC is seeking 1.8 million dollars to develop a battery of test instruments which can be used by schools to assess the personal

qualities of students. These instruments will be available to complement or supplement impressions gained through interviews and letters of recommendation.

In 1956, under AAMC auspices, 28 medical schools joined in a cooperative project to study the career development of students admitted to those schools in that year. This cohort of over 2,500 students was studied with a variety of psychological and sociological measurements. The educational environment of the institutions was also studied. In May of 1976 a major questionnaire survey was mailed to the physicians in this cohort. Through this survey it will be possible to determine not only the specialty, but the type of practice and the location of practice of each of these physicians. During the Fall and Winter of 1976-77, correlations of information gained from this questionnaire will be made with the data gathered during the medical school years. If there are criteria identifiable in medical school applicants and medical students which can predict specialty choice and type and location of practice, they will be called to the attention of the faculties.

Medical schools are constantly appraising and modifying their curricular offerings in order to provide medical education consistent with the rapid advances of biomedical knowledge and the need for new types of health services. During the decade from 1965 to 1975, many schools undertook major curricular revisions which were directed toward the earlier introduction of clinical experience and greater opportunities for students to begin making career

selections early in their educational years. In many schools these revisions provided new opportunities to have positive educational experiences in primary care settings, often in sites remote from the medical school. Educational units in primary care have been developed as well. Ninety-one schools have units for family medicine. Other schools have developed primary care programs based on medicine and pediatrics. The current state of these developments will be re-assessed in the follow-up study on primary care education which is being conducted this summer. By modifying curricula and developing new instructional programs, the medical schools play the major role in keeping undergraduate medical education consistent with available knowledge and the public interest.

The teaching hospitals in the United States have since 1960 increasingly become affiliates of academic medical centers. In 1962 there were 440 teaching hospitals affiliated with the medical schools and 1,034 were not affiliated. In 1973 there were 1,100 affiliated hospitals and only 477 unaffiliated hospitals. The most major of the affiliated hospitals are members of the Council of Teaching Hospitals of the Association. Four hundred hospitals are presently members of the Council of Teaching Hospitals. A survey of 303 short-term, nonfederal Council of Teaching Hospitals was published in May, 1976. Data from this survey show that 60.5% of the internship - residency positions in the U.S. are in these hospitals.[14] Affiliated hospitals which are not members of the Council of Teaching Hospitals also interact with the academic centers in planning and

providing graduate medical education. In the academic year 1973-74, 91% of the 18,076 filled first-year residency positions were in affiliated hospitals. 85% of the filled first-year family practice residency positions were in affiliated hospitals.

Increasingly, medical schools and their teaching hospitals are assuming overall institutional responsibility for graduate medical education. A survey conducted in the Spring of 1974 demonstrated that 62 centers are working toward accomplishing an institution-wide administrative and decision-making approach to the education of residents.[15] This trend will, in the future, make it possible for academic centers to adjust and modify their graduate medical education programs while maintaining their quality.

Forty-three of the 60 member societies of the AAMC's Council of Academic Societies are organizations representing the clinical disciplines. Individual members of these societies are the principal faculty for graduate medical training in the United States. Many of these societies have conducted programs dealing with health manpower issues. At its Annual Meeting in 1974, the Council of Academic Societies, in conjunction with the AAMC's Council of Deans, held a symposium on specialty and geographic physician distribution.

Through membership in the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education, the Association is a major participant in deliberations of importance in determining future specialty distribution. The Association is working towards the upgrading of graduate medical

education in the United States through improvements in accreditation. Achieving improved graduate medical education with greater emphasis on educating students to provide high-quality medical services in all specialties is a major goal of the AAMC.

In summary, the AAMC and its constituent institutions and organizations are the resource for educating physicians in the United States. Thus, the Association plays a major role in influencing the mix of specialty physicians.

5) Does your organization believe the Coordinating Council on Medical Education or the Liaison Committee on Graduate Medical Education should be responsible for determining the appropriate mix of specialty physicians for the United States?

It is the Association's position that the Coordinating Council on Medical Education should assume responsibility for determining the appropriate mix of specialty physicians in the United States. In the health manpower bill drafted by the Association (S.992 and HR.5546), the Coordinating Council was empowered to certify annually to the Secretary those residency positions which should be made available to students in order to achieve national physician manpower goals. The positions to be designated were to be selected from among those offered by graduate medical education programs accredited by the Liaison Committee on Graduate Medical Education.

In the legislation proposed by the Association, the function of designating available positions on the basis of national manpower

needs, and the function of program accreditation, were specifically and intentionally separated. The accreditation of graduate medical education must be based on the quality of the educational program offered. In the accreditation process the resources available are balanced against the number of trainees to be enrolled. The number who can be effectively educated in any graduate medical education program is dependent upon the financial, personnel, and facilities resources available. It is inappropriate to use the power of accreditation to limit or expand the number of students a program may enroll if the purpose of such limitation or expansion is to achieve an overall national specialty balance. Designation of positions which may be filled to achieve this goal should be accomplished independently by an independent agency. The Coordinating Council on Medical Education is an appropriate agency, and, because of its relationship to the Liaison Committee on Graduate Medical Education, the Coordinating Council can accomplish this task while still maintaining the integrity of the accreditation system and the quality of graduate medical education.

The estimation of future physician specialty mixes needed and implementation of a program to adjust training opportunities to achieve predicted needs will be complex and costly. The Coordinating Council on Medical Education will require significant financial resources if it assumes this responsibility.

6) If you believe it would be inappropriate for these organizations to assume this responsibility, who, if anybody, do you believe should fulfill this role?

Should the Coordinating Council not be provided the opportunity to fulfill the responsibility of monitoring and modifying graduate medical education toward perceived manpower needs, the Association believes that a council should be appointed by the Secretary of Health, Education, and Welfare with the following composition: The Assistant Secretary of Health, the Administrator of the Health Resources Administration from the Department of Health, Education and Welfare, the Chief Medical Director of the Veterans Administration, and the President of the Uniformed Services University of the Health Sciences (all ex-officio, non-voting members); and eighteen members appointed by the Secretary with the following composition: ten to be appointed from lists of nominees submitted by the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the American Board of Medical Specialties, and the Council on Medical Specialty Societies; one to be appointed from nominees submitted by the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine; six shall be representatives of consumers of health care; and one shall be a full-time student in an accredited program of graduate medical education.

This council should be required to designate available positions only from programs accredited by the Liaison Committee on Graduate Medical Education. As emphasized in the response to Question 5, the achievement of a national goal for physician specialty distribution should not impair or harm the accreditation process.

7) Has your organization contracted for or conducted any studies dealing with either geographic or specialty distribution of physicians in the United States? If so, would you be kind enough to either send us copies of these studies or advise as to where these can be secured?

The studies pertinent to this inquiry have been referenced. Copies of those which are available are being forwarded under separate cover.

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Director
Department of Academic Affairs

June 7, 1976

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