

MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
BUSINESS MEETING  
February 4, 1972

Palmer House Hotel  
Chicago, Illinois

I. Roll Call

Dr. William B. Weil, CAS Secretary, called the roll. Thirty-six persons represented 33 of the 47 constituent societies. Member societies which were not represented were:

American Academy of Allergy  
American Association of Chairmen of Departments of Psychiatry  
American Association of Neuropathologists  
American College of Surgeons  
American Neurological Association  
Association for Academic Surgery  
Association for Medical School Pharmacology  
Association of Pathology Chairmen, Inc.  
Association of Teachers of Preventive Medicine  
Association of University Professors of Neurology  
Society of Academic Anesthesia Chairmen, Inc.  
Society for Pediatric Research  
Society of Surgical Chairmen  
Society of University Surgeons

II. Approval of Minutes

The minutes of the meeting held October 29, 1971 were approved as circulated.

III. Chairman's Report

The Chairman reported briefly on several items of interest which are described in greater detail later in these minutes:

The AAMC Executive Committee Retreat was held in early December, 1971, during which the matter of institutional faculty representation in the AAMC was

explored in depth. The recommendation for establishment of an Organization of Faculty Representatives, analogous to the Organization of Student Representatives, and related to the Council of Deans, was brought before the Executive Council in its meeting later in December.

Dr. John A. Gronvall, Chairman of the AAMC Task Force on the Cost of Medical Education, appeared before the CAS Administrative Board on February 3, 1972, to bring to the Council's attention the national focus on the arrangements that clinical faculty may have with institutions whereby they are using such facilities for the generation of private income. Dr. Clark is appointing a Committee to explore this complex issue and to suggest ways in which the Council of Academic Societies might generate data that would be useful, keeping in mind the need for any data to be reflected against individual institutional costs and the need for data that would suggest some true measure of the time contributed by voluntary clinical faculty to the medical education enterprise.

IV. Membership Application

ACTION: Upon motion, duly seconded, the CAS Membership voted unanimously to recommend to the AAMC Executive Council the application of the American Association for the Study of Liver Diseases in the Council of Academic Societies.

V. Policy Statement of Eliminating the Freestanding Internship

The Council of Academic Societies considered the following policy statement:

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the

design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

Examples of free-standing internships would include:

- (a) an internship offered in a hospital that has no residency programs and that has no relationship to other hospitals for graduate training;
- (b) an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere.

ACTION: A motion was made and duly seconded to affirm the proposed policy statement of eliminating the freestanding internship. The original motion was subsequently amended, and duly seconded, to affirm the statement through sentence one and including the first clause of sentence two. The amended statement follows:

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the free-standing internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education.

The amended statement was affirmed with two dissenting votes.

VI. Recommendation for the Establishment of an Organization of Faculty Representatives

Dr. Clark traced the evolution of faculty representation in the AAMC from the original Coggeshall Report recommendation for faculty representation from both institutions and from academic societies to the Retreat Proposal for

the Organization of Faculty Representatives (OFR). In the CAS October 29, 1971 meeting a motion "supporting the development of a Council of Faculty within the AAMC" had been tabled because of the scheduled December Retreat of the AAMC Executive Committee. In its deliberations on February 3, 1972 the CAS Administrative Board could not reach a consensus on this item, although it was stated that the proposal for development of the OFR seemed the most viable at this point in time.

ACTION: Motion was made and duly seconded that the "Guidelines for the Organization of Faculty Representatives" on pp. 20-22 in the Agenda book (i.e. that emanating from the AAMC December 1971 Executive Committee Retreat) be approved.

Ensuing discussion primarily opposed the OFR as untenable to the faculty, who might (one said) choose to organize outside the AAMC if no more than token representation would be acceptable to the Deans.

SUBSTITUTE MOTION: The following substitute motion, duly seconded, was offered:

The CAS believes it is imperative to establish a Council of Faculties with the selection of two individuals from each institution, with the interim establishment of an Organization of Faculty Representatives.

(NOTE: This substitute motion was later withdrawn.)

Objections were raised to this compromise motion as an insult.

ACTION: A motion was made and seconded to take the October 29, 1971 motion "supporting the development of a Council of Faculty within the AAMC" off the table. By majority voice vote the motion supporting the development of a Council of Faculty within the AAMC was carried.

The substitute motion was then withdrawn.

ACTION: The vote was then taken on the original motion to establish an Organization of Faculty Representatives. This motion was defeated.

ACTION: A motion was then made and duly seconded to establish a Council of Faculties within the AAMC. This motion passed by a majority voice vote.

NOTE: Underscore added to indicate that this motion differs from the October 29, 1971 motion in being stronger, i.e. the earlier motion passed was "supporting the development of a Council of Faculty..." the latter "to establish a Council of Faculties."

## VII. Federal Activities

Dr. John A.D. Cooper reported on current federal activities and developments of the Coalition for Health Funding. The CAS Membership are kept informed of all major AAMC activities by the AAMC President's "Weekly Activities Report."

ACTION:...On motion, duly seconded, the following resolution was unanimously adopted:

Be it resolved that the CAS via the AAMC and the Coalition for Health Funding express our concern for the proposed decrease in support of the competitive research grant programs for the N.I.H. as contained in the proposed budget for 1973.

### VIII. Liaison Committee on Graduate Medical Education

Dr. Clark next reported on points of agreement reached by Representatives of the American Medical Association, Association of American Medical Colleges, American Board of Medical Specialties, Council of Medical Specialty Societies, and American Hospital Association, at a meeting held on January 25, 1972 in Washington, D.C.

1. As soon as possible, there will be established a Liaison Committee on Graduate Medical Education, with representation from each of the five organizations, to serve as the official accrediting body for graduate medical education.

2. Simultaneously, there will be established a Coordinating Council on Medical Education to consider policy matters for both undergraduate and graduate medical education, for referral to the parent organizations.

3. The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations and with the understanding that Residency Review Committees will continue to function.

4. All policy decisions will continue to be subject to approval by the parent organizations.

5. Policy recommendations may originate from any of the parent organizations or from the two liaison committees but will be subject to review by the Coordinating Council before final action is taken by the parent organizations.

### IX. Workshop Proposal

A straw vote of the CAS membership indicated the majority favored mounting a "workshop on individualizing medical student curricula." Extra-mural support will be sought.

### X. Dues Increase

Current annual dues per member society in the CAS are \$100.00 Annual income generated to support CAS activities for the 47 member societies is, therefore, \$4,700.00. There seemed to be a consensus on the need for an increase

in dues. No dues increase could be effected through the AAMC legislative process until 1973.

A direct capitation formula, to which the Membership had reacted previously, would, it was felt, impose inequitable financial requirements on the larger organizations without concomitant representation, i.e. each society, regardless of size, is entitled to two votes in the Council.

ACTION: The Administrative Board received as a mandate from the CAS membership the development of specific plans for restructuring and increasing dues in the CAS.

XI. Communications

Member societies need to be better informed on activities of the AAMC and CAS. It is, therefore, important that representatives communicate with the organizations they represent more often than their regular annual reports. Representatives now receive on a regular basis the AAMC President's "Weekly Activities Report."

Members of the Administrative Board are available to attend meetings of constituent societies and to acquaint their memberships with current and on-going activities of the AAMC and the CAS. Presentations that have been made to several societies have been well received as highly informative.

XII. Information Items

1. The matter of "Junior Clerkships" presented in the agenda was discussed.
2. The Primary Care Study Committee held its first meeting in January. This committee is charged to study the role,

obligations, and responsibility of the educational process in solving the public's expectation for primary care.

The Committee on Educational Technology for Medicine: Academic Institutions and Program Management (Eugene A. Stead, Chairman) is structuring its report around three primary areas:

1. Intramural organization of medical schools for education;
2. Inter-School organization for sharing of Educational Resources; and
3. Organization of Learning Resources to be Shared (Including Production, Distribution, and Evaluation; Author Recognition; and Copyright).

In addition, the National Library of Medicine has approached the Council of Academic Societies with respect to an inventory of existing, non-print media available in institutions and in academic societies and with respect to developing a roster of experts for evaluation of such materials.

Dr. James Erdmann, Director of the AAMC Division of Educational Measurement and Research, spoke on the future plans for the Medical College Admission Test (MCAT) and solicited CAS participation in its future development.

### XIII. New Business

ACTION: On motion, duly seconded, the CAS voted unanimously to forward the following resolution to the AAMC Resolutions Committee:

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The Association of Chairmen of Departments of Physiology recognizes that significant contributions to the medical education process can be made by the early exposure of students to problems of human biology in non-medical school settings, and encourages the further exploration of these potentialities.



The Association, nevertheless, is convinced that physiology and the related basic medical sciences play an essential role in clinical medicine which cannot be sustained if formal responsibility for education in these areas is removed from the medical environment. We believe that there are aspects of physiology and other basic medical sciences whose relevance to the education of undergraduate and graduate medical students cannot continue to be made evident without constant interchange with other colleagues within the environment of a medical center.

We therefore resolve that the Council of Academic Societies be requested to endorse the concept that schools of medicine continue to include departments of the basic medical sciences to insure adequate representation of these disciplines.

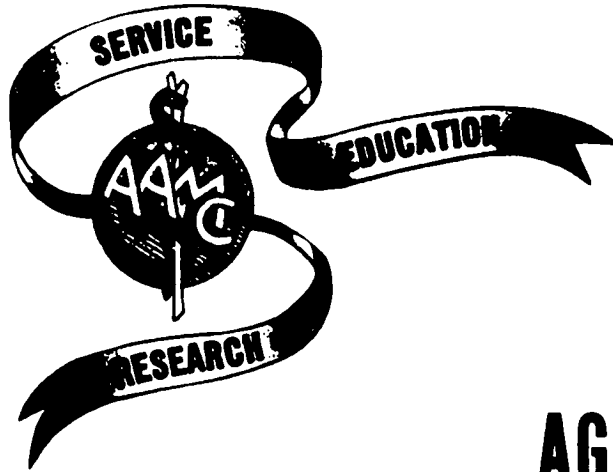
We further resolve that this resolution be communicated to the several societies representative of basic science disciplines in the Council of Academic Societies with the hope that similar resolutions will be adopted by them.

NOTE: The resolution was not accepted by the AAMC Resolution Committee for presentation to the AAMC Assembly due to a lack of data on which the resolution had been based.

XIV. Adjournment

The meeting stood adjourned at 4:45 p.m.

MHL:cw  
2/10/72



**AGENDA**  
**FOR**  
**COUNCIL OF ACADEMIC SOCIETIES**

**BUSINESS MEETING**

Friday, February 4, 1972

1:30 pm - 5:00 pm

Palmer House Hotel

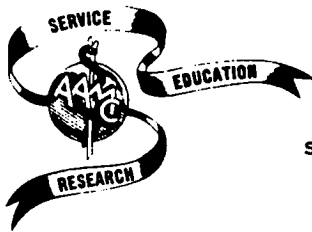
Chicago, Illinois

Parlor B

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

One Dupont Circle

Washington, D. C.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

AGENDA  
COUNCIL OF ACADEMIC SOCIETIES  
BUSINESS MEETING

Friday, February 4, 1972  
1:30 pm - 5:00 pm  
Palmer House Hotel  
Chicago, Illinois

- I. Roll Call
- II. Adoption of Minutes of CAS Meeting, October 29, 1971 1
- III. Chairman's Report
- IV. Action Items:
1. Membership application of the American Association for the Study of Liver Diseases 9
  2. Statement on Freestanding Internships 10
  3. Recommendation for the establishment of an Organization of Faculty Representatives 18
- V. Discussion Items:
1. Expansion of the Liaison Committee on Medical Education to provide for accrediting of both undergraduate and graduate educational programs: The issue of one or two accrediting agencies 23
  2. A workshop on individualizing medical school curricula 24
  3. Increasing member society dues to the Council of Academic Societies 24
  4. "Special Junior Clerkships" in American Medical Schools for U.S. Citizens Studying Medicine Abroad 25
- VI. Information Items:
1. Interim committee reports
    - a. The Committee on Educational Technology for Medicine: Academic Institutions and Program Management
    - b. Primary Care
  2. Health legislation report
  3. Medical College Admissions Test: Plans for the future - Dr. James B. Erdmann, Director, Division of Educational Measurement and Research
- VII. New Business

MINUTES  
COUNCIL OF ACADEMIC SOCIETIES  
Meeting

October 29, 1971

Washington Hilton Hotel  
Washington, D.C.

PLENARY SESSION

A colloquium on Measuring the Effectiveness of Physician Performance, jointly sponsored by the Council of Academic Societies (CAS), the Group on Student Affairs (GSA), and Researchers in Medical Education (RIME), was convened at 1:30 p.m. Dr. James V. Warren, CAS Chairman, served as panel moderator. The parallel was drawn between performance standards for airline pilots and physicians. The analogy included the need for each type of professional having team leadership qualities. The partnership between the public and private sectors in setting standards was emphasized by Captain James C. Waugh of Pan American Airways. The need for a similar partnership for medicine was clearly enunciated by Dr. George Goldberg, Medical Resident from Beth Israel Hospital, Boston, currently serving in the Public Health Service. Dr. Sidney Shindell of the Medical College of Wisconsin developed the concept that in setting standards public expectations from its encounter with the health care system as well as the professional performance of those working in the system must be considered. The session was adjourned at 3:30 p.m.

BUSINESS MEETING

Roll Call

In the absence of Dr. William B. Weil, CAS Secretary, Dr. Sam L. Clark, Jr.,

## CAS Meeting/2

CAS Chairman-Elect, called the roll. Of the 47 constituent societies, 41 were represented.

### Approval of Minutes

The minutes of the meeting held February 12, 1971, were approved as circulated.

### Chairman's Report

The Chairman called attention to the CAS Annual Report which was published in the AAMC Annual Report, 1970-71 and mailed to all CAS representatives before the meeting.

1. The report of the CAS Ad Hoc Committee on Biomedical Research Policy was published in the Journal of Medical Education for August, 1971. Pursuant to the CAS motion, the AAMC Executive Council authorized establishment within the AAMC of a Biomedical Research desk. Recruiting for this post is currently in progress.
2. Dr. Donald J. Hanahan, who served as a member of the Ad Hoc Biomedical Research Policy Committee, is heading the Research Funding Subcommittee of the AAMC Committee on the Financing of Medical Education.
3. The report of the Biomedical Communications Network Committee, headed by Dr. Eugene A. Stead, appeared as a supplement to the Journal of Medical Education for July, 1971. A second committee, also under Dr. Stead's leadership, has been formed to formulate recommendations for the implementation of the report.

4. The activity on Physicians Assistants has been coordinated with the American Medical Association and other agencies.
5. The Committee on Primary Medical Care has recently been appointed. Dr. Thomas K. Oliver, Jr., Chairman of Pediatrics at the University of Pittsburgh School of Medicine, is chairing this committee.

Approval of New Rules and Regulations

The Council of Academic Societies unanimously approved the Rules and Regulations appearing in the Agenda, pp. 9-18.

Policy Statement of the Responsibility of Academic Medical Centers for Graduate Medical Education

A great deal of discussion regarding this statement, appearing on page 19 of the Agenda, resulted in the following motions:

1. The motion was made and seconded to adopt the statement;
2. An amendment to the motion was made and duly seconded to adopt only the first paragraph and drop the balance. The amendment to the motion was defeated.
3. An amendment, duly seconded, was then offered to delete the word, "Policy," in the title. This motion was passed. The title, therefore, reads "Statement on the Responsibility of Academic Medical Centers for Graduate Medical Education."

NOTE: This statement was approved by the AAMC Assembly on October 30, 1971 with the addition of the word, "ultimately," to sentence one.

### **Statement on Graduate Medical Education**

*Following is the complete text of the "Statement on Graduate Medical Education" approved by the AAMC Assembly October 30:*

The Association of American Medical Colleges endorses the concept that graduate medical education ultimately should become a responsibility of academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop, in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by academic medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment; review curricula and instructional plans for each specific program; arrange for evaluating graduate student programs periodically; and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs which are not

now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review, and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools.

The Association urges that the Liaison Committee on Medical Education, the Residency Review Committees, and the Specialty Boards establish procedures which will provide for adequate accreditation of an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.

The report of the AAMC Ad Hoc Committee on Graduate Medical Education expressing the implications of this statement will be published in the February issue of the Journal of Medical Education.

Proposal to have Faculty Representatives from the Medical Schools in the CAS.

The following proposal, which appeared in the agenda was discussed.

*The Council of Academic Societies shall be expanded to include 2 representatives from the faculty of each institutional member of the AAMC. Said representatives should be chosen from faculty mem-*

*bers below the rank of full professor and their selection should insure significant faculty input in the selection process. The method of selection at each institution should be made known to the Administrative Board of the CAS.*

*One representative should particularly represent faculty interests in biomedical research and the other in medical education and instructional innovation.*

*These institutional representatives shall have full voting privileges in the CAS and may serve on the Administrative Board.*

*The Administrative Board of the Council of Academic Societies shall be expanded by 2 members and not less than 2 positions on this Board shall be filled by faculty institutional representatives. But more than 2 may be nominated and elected.*

ACTION: The motion to adopt the proposal was made and seconded.

Discussion: Primary objections to the proposal were (1) the stipulation of "rank" in paragraph one and (2) paragraph two in its entirety.

ACTION: A motion to table was made, duly seconded, and passed. It was suggested that the record show acknowledgment by the CAS of the need for faculty representation and development of mechanisms for representation of young faculty within the AAMC.



An objection was then offered to the stipulation that the faculty be "young" rather than "junior."

The Chairman then called for a straw vote on the question of representation of faculty from institutions within the AAMC. The majority were in favor of such representation.

ACTION: A motion was then made, and duly seconded, supporting the development of a Council of Faculty within the AAMC. This motion was subsequently tabled.

The consensus of the discussion appeared to be that the present CAS membership makeup consisting of disciplines on a national level had unique qualities and that the addition of institutional faculty members, while desirable by the AAMC, should be studied further by AAMC.

#### Admission of New Member Societies

ACTION: On motion, duly seconded, applications for membership of the following five societies were approved:

1. American Federation for Clinical Research
2. American Association of Immunologists
3. Association of Medical School Microbiology Chairmen
4. Society of Teachers of Family Medicine
5. Southern Society for Clinical Investigation

#### Election of Officers and Administrative Board

The report of the Nominating Committee appeared in the Agenda. The membership requested that in the future they be given background information on those nominated ahead of the meeting. The Chairman asked those nominated to stand. Of those nominated to office, Dr. Clark and Dr. Gregory were the

CAS Meeting/7

only ones present.

Officers.--Elected as officers for the coming year were: Dr. Sam L. Clark, Jr., Chairman; Dr. Robert G. Petersdorf, Chairman-Elect; and Dr. William B. Weil, Secretary.

Administrative Board. --In addition to the officers listed above the following were elected to two-year terms on the Administrative Board (formerly known as the Executive Committee): Dr. Robert E. Forster, Dr. Ludwig Eichna, and Dr. Charles F. Gregory.

A list of the current membership of the CAS Administrative Board is appended to these minutes as Appendix A.

#### CAS Representatives

The CAS was requested to send to Dr. Swanson's office names, addresses, and terms of office of current CAS representatives.

#### Next Meeting

The Council of Academic Societies and the Council of Deans will have a joint meeting at the AAMC Meeting in Chicago's Palmer House beginning 9:00 a.m. on Friday, February 4, 1972.

#### \*Adjournment

The meeting was adjourned at 5:30 p.m.

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\*An open CAS faculty forum from 8:30 to 10:30 p.m. drew some 50 individuals. Moderating the session were Dr. Warren, Dr. Clark, and Dr. Swanson. Topics discussed were: AAMC Committee on Educational Technology for Medicine: Roles for the Lister Hill Center by Dr. Cheves McC. Smythe, Dean University of Texas Medical School, Houston, Texas; Policies and Plans of the National Intern and Resident Matching Program by Dr. John Nunemaker, Director NIRMP; and Cancer Legislation, Liaison Committee on Medical Education Expansion, and Accreditation for Physicians' Assistants, by AAMC Staff.

COUNCIL OF ACADEMIC SOCIETIES  
Administrative Board  
1971 - 1972

CHAIRMAN

Sam L. Clark, Jr., M.D., Chairman  
Department of Anatomy  
University of Massachusetts  
School of Medicine  
419 Belmont Street  
Worcester, MA 01604

Charles Gregory, M.D., Chairman  
Department of Orthopedic Surgery  
Southwestern Medical School  
at Dallas  
University of Texas  
5323 Harry Hines Boulevard  
Dallas, TX 75235

CHAIRMAN-ELECT

Robert G. Petersdorf, M.D.  
Professor and Chairman  
Department of Medicine  
University of Washington  
School of Medicine  
Seattle, WA 98105

Ernst Knobil, Ph.D., Chairman  
Department of Physiology  
The University of Pittsburgh  
School of Medicine  
Alan Magee Scaife Hall of the  
Health Professions  
Pittsburgh, PA 15213

SECRETARY

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Department of Human Development  
Michigan State University  
College of Human Medicine  
East Lansing, MI 48823

Louis G. Welt, M.D.  
c/o Professor Sir Hans Krebs  
Nuffield Dept. of Clinical Med.  
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Oxford OX2 6HE  
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Brooklyn, NY 11203

\*Jonathan E. Rhoads, M.D., Chairman  
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Ronald W. Estabrook, Ph.D., Chairman  
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Southwestern Medical School  
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The Ohio State University  
University Hospital  
410 West Tenth Avenue  
Columbus, OH 43210

Robert E. Forster, II, M.D., Chairman  
Department of Physiology  
University of Pennsylvania  
School of Medicine  
Philadelphia, PA 19104

Representatives to the AAMC  
Executive Council

Sam L. Clark, Jr., M.D.  
Ernst Knobil, Ph.D.  
Jonathan E. Rhoads, M.D.  
James V. Warren, M.D.

\*Ex Officio

1. Name of Society

American Association for the Study of Liver Diseases

2. Purpose

To aid and encourage research in liver diseases, by any means in the Association's power; (b) endeavor to improve methods of diagnosis and treatment of liver diseases; and (c) further the knowledge of liver diseases by seminar discussions of problems pertaining to such diseases.

3. Membership

Any scientist who has contributed to the study of liver diseases, including therein investigators in the various fields of biochemistry, physiology, biology, pathology, experimental medicine as well as clinical investigations.

4. Number of Members

250

5. Constitution and bylaws available

6. Minutes of the 20th Annual Meeting (including agenda), held October 29-30, 1969, are available.

7. Organized

November 3, 1949

8. Recommendation

10/10/70 - Executive Committee deferred application

12/16/71 - CAS Administrative Board approved application

## POLICY STATEMENT OF ELIMINATING THE FREESTANDING INTERNSHIP

At its December meeting, the House of Delegates of the AMA approved the concept that the freestanding internship should be eliminated. Subsequently, memoranda from the AMA's Council on Medical Education were circularized on December 28, 1970 and March 18, 1971, explaining the implications of this policy.

The AAMC has made no public statements regarding this development. It is clear that eliminating the freestanding internship is consistent with the development of a more logical continuum of medical education and with the policy statement which was passed by the Assembly in October regarding the responsibility of academic medical centers for graduate medical education.

A committee consisting of Dr. John Parks (COD), Dr. Tom Kinney (CAS), Mr. Irvin Wilmot (COTH) and Dr. August Swanson (Staff) met on September 3rd and developed the following statement.

The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

At the Executive Council Meeting in September action on the statement was tabled. At the Executive Council Meeting in December the statement was referred to the Councils for discussion and action. Following action by the three councils the statement will be referred to the Assembly for final action. Assembly action will not be possible until the fall meeting 1972.

The memorandum which follows defines the intent of the AMA's resolution on eliminating the freestanding internship. Your attention is particularly called to Page 3 of the memorandum dated March 18, 1971 which defines the freestanding internship and also gives examples of the integration of the first year of graduate education.



COUNCIL ON  
MEDICAL EDUCATION

## AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 527-1500 • TWX 910-221-0300

### M E M O R A N D U M

TO: All Directors of Approved Graduate Training Programs  
All Deans of Medical Schools  
All Medical Specialty Boards  
All Residency Review Committees  
All Medical Specialty Societies Represented on Residency Review  
Committees

FROM: C. H. William Ruhe, M.D.,  
Secretary, AMA Council on Medical Education

SUBJECT: Implications of Recent Actions to Integrate Internship and  
Residency Programs

DATE: March 18, 1971

On December 28, 1970, a memorandum was sent to all hospitals with approved graduate programs reporting recent actions by the American Medical Association aimed at integration of internship and residency education and emphasizing the continuum of undergraduate and graduate medical education. The present memorandum is intended to amplify and explain that report, and to consider the implications of the unification of graduate training programs.

The Council on Medical Education has approved the following statements for the guidance of program directors:

1. Unification of internship and residency years into a coordinated whole implies that the total program must be directed by one individual. This person must necessarily, therefore, have the responsibility and authority for direction of the residency program in that specialty, and he must be responsible for preparation of the entire application, describing all years and the relationship of each year to the others.
2. The program director should have the option of either requiring or recommending a specific type of "internship year" acceptable as a part of his residency program, depending upon the resources of the institution and the undergraduate experience and career objectives of the candidate.
3. The program director should have the option of designing the internship year as a traditional rotating experience, a rotating experience with a specified

Memorandum-Implications of Recent Actions to Integrate Internship and  
Residency Programs

March 18, 1971

major, or a straight experience limited largely to the specialty field concerned. He should have complete freedom in the design of this internship year and would not need to designate it by any of the above three standard terms. The program director should have the option of including within the internship year specific experiences of particular value to the trainee in his future career, even though the specialty board concerned may have stated that it would not give credit for certain of these experiences toward eligibility for certification.

The institution has the ultimate, corporate responsibility; the program director has the administrative responsibility, but, in order to exercise this responsibility, he should have available the collective judgment of his counterparts in the related specialties.

4. The program director might elect to assign the trainee to an outside hospital for his internship year, would assume responsibility for his educational program for that period of time, and would have to describe in a convincing way those elements of the outside program that assure coordination with the program in the parent hospital. He might also accept trainees who have had experience in other institutions approved for such training.
5. The program director would have to specify the conditions under which a candidate appointed to the first, or internship, year would be eligible for appointment to the subsequent years of the program.

The Future Status of the Internship

When the House of Delegates adopted the statement in Report L of the Board of Trustees, in June, 1970, some program directors interpreted the action on the "free-standing internship" to mean that the rotating internship was being abolished; others interpreted it to mean that any internship in a hospital without a medical school affiliation was being abolished; some simply assumed that all internships were being abolished.

The action of the House of Delegates did not abolish internships, but did require that they be made an integral part of a total program of graduate medical education. Deadlines have been set far enough in advance to permit institutions to reorganize their programs of graduate medical education in order to be able to conform to these requirements if they wish to continue to offer such education.

The term "free-standing internship" has been misinterpreted by a number of program directors. It was intended to indicate those internships not related

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Memorandum-Implications of Recent Actions to Integrate Internship and  
Residency Programs

March 18, 1971

to residencies, whether the residencies are in the same hospital as the internship or in other hospitals.

1. Examples of free-standing internships would include:
  - (a) an internship offered in a hospital that has no residency programs and that has no relationship to other hospitals for graduate training;
  - (b) an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere.
2. Examples of an internship, or first year of graduate education, integrated with residencies, would include:
  - (a) a rotating internship in one hospital integrated with one or more residencies within that hospital;
  - (b) a rotating internship in one hospital integrated with one or more residencies in another hospital;
  - (c) a straight internship within one hospital integrated with a residency in that specialty, either solely in that hospital or in a group of hospitals;
  - (d) a straight internship structured on the same lines as the residency and integrated in two or more hospitals for the entire training period;
  - (e) a straight internship in two or more hospitals integrated with a residency offered in only one of the hospitals.

Critical Mass

In the report adopted at the December, 1970 meeting of the House of Delegates, entitled "Continuum of Medical Education," Item 8 expresses the need for a "critical mass" within any hospital approved for graduate medical education. A successful graduate training program cannot be carried out in a vacuum. However, because the minimum requirements differ from specialty to specialty, the minimum critical mass for good training must be determined for each specialty. In internal medicine, for example, there must be a residency in general surgery. For a residency in family practice, there must be creditable departments of radiology and pathology. The general requirements stated in the "Essentials of Approved Residencies" are applicable to all programs, and provide minimal safeguards.

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Memorandum-Implications of Recent Actions to Integrate Internship and  
Residency Programs

March 18, 1971

The director of a unified program of graduate medical education must be responsible to insure that the trainees in his program are adequately grounded in such of the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology as are appropriate to the program and to individual career goals. The Council on Medical Education and its Advisory Committee on Graduate Medical Education recognize the value of the concept of a basic two years of graduate education, from the standpoint of facilitating lateral mobility and allowing the candidate to delay committing himself to a premature choice of a specialty. Nevertheless, the Council also recognizes the fact that there is currently a strong trend in students toward early branching within the undergraduate program. Thus there could be a conflict between the desire to shorten the total span of specialty education and the desire to provide breadth of training before the candidate concentrates on narrower specialty training.

Program directors should structure graduate training programs so that they provide not only the requisites acceptable to the specialty boards but also insure that adequate breadth of training is provided without significantly prolonging the total span of training. One step in this direction is the acceptance by most of the examining boards in the surgical specialties of the principle of an examination after a basic two years of surgical training.

Cooperation of Other Organizations and Agencies

Coordination and integration of internships and residencies can be carried out only with the effective cooperation of medical schools, state licensing boards, and the examining boards in the medical specialties. The medical schools in many instances are studying their curricula, and are considering the possibility of concentrating undergraduate medical education in such a manner that at least a portion of the final year can be used to provide graduate education. University faculties, jointly with the faculties of their affiliated hospitals, should assume greater corporate responsibility for the conduct of graduate education, to insure that a meaningful experience is afforded each graduate. In order to produce a greater number of physicians to provide for the delivery of health care, cooperative efforts should be developed and encouraged between university faculties and community hospitals.

Both the December 28, 1970 Memorandum and the present Memorandum have been sent to all state licensing boards so that each of these agencies will be aware of the fact that, as of July 1, 1970, the Council on Medical Education considers the first year of any approved residency program, including that of family practice, as the equivalent of an internship approved by the American Medical Association. This policy should make it possible for trainees to obtain some of the experience normally available in an internship during their fourth year

Memorandum-Implications of Recent Actions to Integrate Internship and  
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of medical school, so that, upon graduation, they could be accepted into the first year of a residency program, provided the specialty board in that field does not require an internship, or will give credit for clinical experiences obtained in the final year of medical school.

The American Board of Medical Specialties, which now acts as the coordinating body for the approved examining boards, has also been notified of the adoption of these policies. It is hoped that the specialty boards will give consideration to the possibility of providing credit toward certification for appropriate clinical experience obtained prior to the granting of the M.D. degree, and consider also the possibility, in those specialties requiring three or more years of graduate experience, of permitting substitution of at least one year of graduate education in medicine, surgery, pediatrics, or family practice, for stated requirements of the individual boards.

If the specialty boards find it possible to reorient their requirements for certification so that less emphasis is placed on calendar perimeters, future graduate programs could be designed in such a way that the house officer would be able to achieve his educational goal in as short a time span as possible, based on the program director's individual evaluation of the trainee, which would take into consideration the latter's personal motivation and learning capabilities.

Future Procedures and Evaluations

The effective date of July 1, 1975, was chosen to provide for the orderly implementation of these policies, and to give program directors, medical schools, specialty boards, and licensing boards an opportunity to develop effective implementation of the recommendations.

It seems desirable that, for the present at least, the principle of a voluntary matching program for graduate medical education be preserved. The only point at which this can be preserved is at the time of obtaining the M.D. degree. In the case of a specialty for which the board does not require an internship, there may be developed a matching of the first year of the residency. This is being done on a limited basis in the March, 1971 Matching Program, and a separate matching program has been carried on during the past year for residencies in radiology and in orthopedic surgery, both of which specialties do require an internship.

It has been the policy of the Department of Graduate Medical Education to survey approved programs at intervals of about thirty to thirty-six months. This schedule of surveys will be maintained during the years intervening prior to July 1, 1975, and programs will be evaluated during that time on the basis of previous "Essentials of an Approved Internship" and "Essentials of Approved Residencies."

Memorandum-Implications of Recent Actions to Integrate Internship and  
Residency Programs

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During the past year, as many program directors are aware, straight internships in internal medicine, surgery, obstetrics-gynecology, and pediatrics have been evaluated by the residency review committees in such specialties, and the straight internships in pathology have been evaluated by the American Board of Pathology along with residencies in that specialty. The rotating internships are currently evaluated by the Internship Review Committee, which will continue to carry on this responsibility at least until 1975.

Applications for new, free-standing internships in general will not be accepted for survey unless it can be shown that the program would be implemented as of July 1, 1971. Program directors considering the establishment of a rotating internship at this time should plan an intramural program of internship and residency training or should develop affiliations with other hospitals so that such a coordinated program could be offered. Many hospitals might also be eligible to consider the possibility of offering a three-year family practice program, the first year of which can be credited as an internship.

RETREAT DISCUSSION OF  
FACULTY REPRESENTATION IN THE AAMC

The question of faculty representation served as the focus of discussion at the AAMC's recent Retreat (December 2-4). At issue was the basic justification for such an expansion, the mechanism by which this might best be accomplished, and all long-range implications of such an action on the Association.

Discussion of these questions stimulated a wide range of opinion. While there was general agreement on the value of involvement of the faculties, several questions were raised concerning their role in the governance of the Association. One questioned the possibility of "representation," stating that only the individual delegate would be involved and that nothing would be done to involve or truly represent the whole of the faculty. Another concern was the manageability of the Association: have we reached a critical mass beyond which point proliferation will eventually lead to paralysis.

Extensive debate on these points established a general consensus in favor of formally involving the institutional faculty in both the substance and governance of the Association. As was noted in support of this viewpoint, a primary concern of the AAMC, by definition, is medical education, and this task must eventually be accomplished by the faculty. Seven options for incorporating faculty into the governance of the Association were then solicited:

- 1) abolish CAS in favor of a Council of Faculties (COF), which would provide for subordinate representation of the professorial societies;
- 2) retain CAS and establish an Organization of Faculty Representatives (OFR) within the COD--parallel to the OSR;
- 3) expand CAS to incorporate junior faculty (possible rename COF);
- 4) establish voluntary campus chapters of the AAMC. Bring a representative of each chapter directly into either CAS or COD. When 50% of the faculties were so organized, they would form a separate council (COF);
- 5) reorganize regional meetings only, to include COF (Midwest example);
- 6) retain CAS and establish COF;

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Prepared by AAMC for discussion at December 17, 1971 Executive Council meeting.

- 7) replace COD with a Council of Institutional Representatives (CIR). Each school would have three delegates -- dean, faculty member, student--and one vote.

It was decided that two separate issues had to be resolved: first, how this faculty body is to fit into the AAMC governing structure, and second, how the faculties are to be organized to select a representative.

After much discussion, a consensus was reached on Option #2 above-- establishing an Organization of Faculty Representatives under the Council of Deans. An integral part of this consensus was the agreement that this proposal would be presented to and discussed by each of the constituent Councils before going to the Assembly in November. It was also agreed that a moratorium be declared on future expansion of the Association until such time as all the implications of this expansion could be evaluated.

The question of organizing the faculty elicited two different proposals: (1) election of a representative by the whole of the organized faculty (Academic Senate); or (2) establishment of voluntary campus chapters, composed of those faculty members who hold AAMC individual membership and who would elect a representative from their chapter.

While the value of encouraging individual membership was recognized, consensus was reached on the first alternative. The feeling was expressed that the second option would be time-consuming, would leave some schools without faculty representation, and would tend to represent "joiners." It was also described as a "poll tax."

Thus, consensus was reached on an Organization of Faculty Representatives, structurally equivalent to the Organization of Student Representatives, both in its relationship to the governance of the AAMC and in its membership requirements. It was also agreed that AAMC staff would prepare a proposal to transmit this consensus to the December Executive Council meeting for "rigorous debate" and for referral to the February meetings of the CAS, COD, and COTH. A progress report will be presented to the February Assembly meeting, and receipt of the proposal (with amendments and recommendations) from the Councils will be expected at the May 19th meeting of the Executive Council. Final action is aimed at the November Assembly.

This paper and the attached draft Guidelines are therefore submitted to the Executive Council for the review and referral mentioned above.

GUIDELINES FOR THE  
ORGANIZATION OF FACULTY REPRESENTATIVES

## ORGANIZATION

There shall be an Organization of Faculty Representatives which shall be related to the Council of Deans and which shall operate in a manner consistent with Rules and Regulations approved by the Council of Deans.

## COMPOSITION

The OFR shall be comprised of one representative from each Institutional Member and Provisional Member of the COD, chosen from the full-time faculty of each such member.

## SELECTION

A faculty representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will insure representative faculty input and be appropriate to the governance of the institution. The dean of each participating institution shall file a description of the process of selection with the Chairman of the COD and shall certify to him annually the name of the faculty member so selected.

## MEETINGS

Annual Meeting. The OFR shall meet at least once a year at the time and place of the COD Annual Meeting in conjunction with said meeting.

To facilitate the smooth working of the organizational interrelationships, the above shall be interpreted to require that the Annual Meeting of the OFR be held during the period of the Association's Annual Meeting, not simultaneously with the COD meeting. This meeting will be scheduled in advance of the COD meeting at a time which will permit the attendance of interested or designated deans.

## ACTIVITIES

The OFR will:

- Elect a Chairman and a Chairman-Elect.
- Recommend to the COD the Organization's representatives to the Assembly. (10% of OFR Membership)
- Consider other matters of particular interest to the faculty of Institutional Members.
- Report all actions taken and recommendations made to the Chairman of the COD.

## RELATIONSHIP TO COD

The Chairman and Chairman-Elect of the OFR are invited to attend the COD meetings to make such reports as requested of them by the COD Chairman, to act as resource persons to express the concerns of faculty when invited, and to inform themselves of the concerns of the deans.

## RELATIONSHIP TO THE EXECUTIVE COUNCIL

The Chairman of the OFR shall be an ex officio member of the Executive Council with voting rights.

## RELATIONSHIP TO THE ASSEMBLY

The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the COD and a number of the OFR equivalent to 10 percent of the members of the Association having representatives in the OFR.

Each such representative (to the Assembly) shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings.

The Chairman of the Assembly may accept the written statement of the Chairman of the COD reporting the names of individuals who will vote in the Assembly as representatives chosen by the OFR.

## COMMITTEES

One representative of the OFR to the Assembly shall be appointed by the Chairman of the Assembly to sit on the Resolutions Committee.

## RULES AND REGULATIONS

The OFR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

## FINANCES

- The Association will meet the cost of the travel required for authorized faculty participation in Association committee activities, i.e., Executive Council, Administrative Board, and designated committee meetings.



- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with faculty participation will have to be individually arranged at the institutional level.
- Association funds required to support this organization must be reallocated from currently budgeted funds reducing activities in other areas.

## V. Discussion Items:

1. Expansion of the Liaison Committee on Medical Education to provide for accrediting of both undergraduate and graduate educational programs: The issue of one or two accrediting agencies.

At the present time undergraduate medical education programs are accredited by the Liaison Committee on Medical Education, and clinical graduate programs (residencies) are accredited by 21 Residency Review Committees. For a number of years it has been clear that the accreditation of graduate medical education must be made the responsibility of a single agency. The Millis Commission recommended that a Commission on Graduate Medical Education be established; but the rapid changes in undergraduate medical education, which have occurred since the report of that Commission, made it appear desirable to have a single agency responsible for both undergraduate and graduate medical education accreditation.

The Liaison Committee on Medical Education presently consists of five members from the Council on Medical Education of the AMA and five members of the AAMC. For the past several years there have been negotiations to expand the Liaison Committee to include representation from the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialties Societies. Public and Federal representation has been included in the negotiations. This expanded Liaison Committee would take responsibility for accrediting both undergraduate and graduate programs in academic medical centers and teaching hospitals.

There is a consensus among medical educators that the education of a physician should be viewed as a continuum, extending from entrance into medical school until graduate medical education is completed. Thus it is highly desirable to provide an accreditation system which recognizes this continuum and which will promote its development in the medical education system.

Expansion of the Liaison Committee has been strongly supported by the AAMC and the Liaison Committee on Medical Education has come forward with several plans. Various proposals have been blocked. The major debate centers around which organizations should be represented and the number of representatives from each organization.

In May 1971 the American Board of Medical Specialties approved a resolution that the American Board of Medical Specialties and the Council on Medical Education of the AMA form a separate Liaison Committee on Graduate Medical Education. This resolution was opposed by the AAMC representatives at the ABMS meeting.

During the last six months there have been a variety of negotiations regarding both the expansion of the Liaison Committee and the development of a separate accrediting committee for graduate medical education. The AMA established a "negotiating committee" to meet separately with each organization's governing board. The ABMS and the AMA's "negotiating committee" endorsed the concept of a separate committee. The AHA and the CMSS have not committed themselves to this concept. The AAMC declined to meet with the "negotiating committee" and convinced the AMA that all organizations concerned should be brought together to finalize a plan for the expansion of the Liaison Committee. The outcome of this meeting on the 25th of January will be reported to the CAS.

Discussion of this issue is needed in the Council in order that the position of medical educators who are largely responsible for both graduate and undergraduate medical education can be made clear.

\* \* \* \*

2. A workshop on individualizing medical school curricula.

The Administrative Board discussed the problems developing in relationship to public pressures to shorten undergraduate medical education. The Board concurred with the view that medical education should be individualized to meet the needs of students with varying backgrounds and with differing career goals. The Board believes that it is desirable to have a special workshop on individualizing medical student curricula. Floor discussion on this proposal is desired.

\* \* \* \*

3. Increasing member society dues to the Council of Academic Societies.

During the summer of 1971 a proposal to increase member society dues to the CAS was circulated to all societies. The proposal was that societies with less than 200 members pay \$200 per year, societies with 200 - 5,000 members pay \$1.00 per member per year and societies with more than 5,000 members pay \$5,000 per year.

The responses to this proposal were clearly divided between the large and small societies. The small pro-

fessorial societies generally favored the proposal; large societies questioned whether or not they could or should pay dues ranging as high as \$5,000 per year.

The present \$100 per year membership fee generates only \$4,700. This represents less than 1% of the AAMC income from dues. The staff work generated by the Council and the cost of the support of the activities of the Council are thus a drain on the total resources of the AAMC. An equitable plan for increasing dues is needed. Ideally any plan should generate approximately \$50,000 per year.

\* \* \* \*

#### 4. "Special Junior Clerkships" in American Medical Schools for U.S. Citizens Studying Medicine Abroad.

The Council on Medical Education of the American Medical Association adopted a policy statement on June 23, 1971, recommending that the AMA allow U.S. citizens who have studied medicine abroad to enter AMA-approved residencies even though they have not fulfilled all the requirements for graduation of the institution they are attending. As an alternative to fulfilling the foreign medical schools institutional requirements, the Council on Medical Education recommends that U.S. medical schools provide a special junior clerkship separate and distinct from the usual junior clerkship provided by the school to its own students to these U.S. citizens. The Council further provides that U.S. schools not take these students until they have passed an examination such as Part I of the National Boards, the ECFMG Examination or the FLEX Examination.

The purpose of this policy is to allow U.S. citizens to escape the necessity of meeting requirements for assigned social service. This is a particular requirement in Mexico. Students accepted under this policy will not be granted their degree by the foreign school. The U.S. schools accepting these students are also not expected to grant a degree.

Recognizing that well-qualified students are obtaining their medical education in foreign medical schools, the AAMC established the Coordinated Transfer Program (COTRANS) in 1970. COTRANS has provided a centralized system to coordinate the collection of documents, the verification of eligibility for Part I of the National Boards and the dissemination of this information to medical schools interested in accepting transfers of U.S. citizens from foreign schools. Through COTRANS, qualified students who can pass Part I of the National Boards are provided a maximum opportunity for gaining entrance to the clinical programs of our schools. One hundred twenty-one students transferred to U.S. schools in the first year of COTRANS. Eighty-two were arranged through COTRANS. Thirty-nine arranged their transfers independently.

Presumably, Part I of the National Boards would be inappropriate for the students admitted to the proposed junior clerkships. Because, if they can pass Part I of the National Boards, they can be accepted into American medical schools through the COTRANS program and receive their clinical training and their degree from the accepting institutions. It is likely that an examination such as the ECFMG or the FLEX Examination will be recommended. Both of these examinations place a heavier emphasis on clinical knowledge and a lesser emphasis on basic science knowledge.

While each school must make a decision whether or not to develop special junior clerkships, the Council should be informed and discuss the general policy question set forth by the action of the CME. Attached are copies of the policy statement and the tentative guidelines proposed by the CME.

## American Students in Foreign Medical Schools \*

The established policy of the American Medical Association with reference to the eligibility of foreign medical graduates for appointment to approved internships or residencies is modified as follows:

1. A new pathway for entrance to AMA approved internship and residency programs, other than those existing under previous AMA policies, is available as of July 1, 1971, for students who have fulfilled the following conditions:
  - (a) have completed, in an accredited American College or university, undergraduate premedical work of the quality acceptable for matriculation in an accredited U. S. medical school,
  - (b) have studied medicine at a medical school located outside the United States, Puerto Rico, and Canada, but which is recognized by the World Health Organization,
  - (c) have completed all of the formal requirements of the foreign medical school except internship and/or social service.
2. Students who have completed the academic curriculum in residence in a foreign medical school and who have fulfilled the above conditions may be offered the opportunity to substitute for an internship required by a foreign medical school, an academic year of supervised clinical training (such as a clinical clerkship or junior internship) prior to entrance into the first year of AMA approved graduate medical education. The supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education.
3. Before beginning the supervised clinical training, said students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must pass a screening examination acceptable to the Council on Medical Education, such as Part I of the National Board examinations, or the ECFMG examination, or the FLEX examination.
4. Said students who are judged by the sponsoring medical schools to have completed successfully the supervised clinical training are eligible to enter the first year of AMA approved graduate training programs without completing social service obligations required by the foreign country or obtaining ECFMG certification.
5. The Council on Medical Education will recommend to all state boards of medical examiners that they consider for licensure all candidates who have completed successfully the supervised clinical training on the same basis as they now consider foreign medical candidates who have received ECFMG certification.

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\*Policy Statement of the Council on Medical Education  
Adopted June 23, 1971

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## U.S. CLERKSHIPS FOR U.S. CITIZENS STUDYING MEDICINE ABROAD

### TENTATIVE GUIDELINES

The following guidelines are intended to relate specifically to the needs of American students who have completed four years of study at the Universidad Autonoma de Guadalajara, for remedial clerkships in accordance with the recommendations of the Commission on Foreign Medical Graduates and the Council on Medical Education. In addition, these guidelines are developed with the possibility that they will be of more general usefulness if similarly oriented clerkships are found to be necessary for individuals who have attended other foreign medical schools.

The following comments are intended to be suggestions, with final decision in all important areas to be made by the sponsoring U.S. medical school:

It should be recognized that the students who have been granted a Carta Pasante from the Universidad Autonoma are a heterogeneous group. The group contains a number of individuals who in less competitive times would have been able to gain admission to a United States medical school as well as students who should not be, under any circumstances, expected to pursue successfully a medical school career in the United States. These guidelines are intended to encourage clerkship training for the first group. Specifically, reasonable efforts should be made to direct the remedial education and training to those students who are of approximately the same order of competence as students admitted to U.S. schools. Alternate lists kept by some medical schools might be useful in this matter. Each U.S. school will need to develop its own means of assuring competence. The schools are not being urged to provide remedial training for students who are far below their minimal standards.

Those American educators who have had experience with Guadalajara students and those individuals who have studied the Guadalajara school are agreed that at the end of four years of training, the students, i.e. the holders of the Carta Pasante or Diploma, usually will have had little clinical experience. Many, in fact, have had no formal introductory courses in history taking and physical examination, and none has had clinical experience comparable to that in the typical American clerkship.

The following are suggested as guidelines for the clerkship:

- (1) The feasibility of providing the students with individualized instruction in history taking and physical examination at the onset of the clerkship should be considered.

U.S. CLERKSHIPS FOR U.S. CITIZENS ABROAD

2.

(2) In keeping with the recommendation of the Commission on Foreign Medical Graduates, the clerkship should be one full academic year in duration.

(3) In view of the need for general experience, it is suggested that the clerkship cover several of the more general disciplines. The Mexican "internship" for which this clerkship is intended to be a substitute is comprised of three months each of medicine, surgery, pediatrics, and obstetrics-gynecology.

(4) The clerkship should be under the sponsorship of a U.S. medical school which should have responsibility for the program. It is suggested that these students should not be trained side by side with American medical students since their background is quite different. It is suggested, however, that the training be in a hospital affiliated with the medical school and under the supervision of physicians who hold medical school appointments.

(5) The medical school should have final responsibility for determining the criteria for admission to the program, the characteristics of the program itself, and the evaluation (if any) at the end. The minimum requirement would be for the medical school to certify to the Universidad Autonoma that the student had been in attendance for the full duration of the clerkship.

(6) There must be a screening examination which, combined with evaluation of other credentials, would provide assurance of competence to undertake the clerkship. It is suggested that Part I of the National Board Examination or the first part of Flex might be suitable for this purpose.

(7) It is suggested that it would be highly desirable for the medical school, in addition to providing whatever evaluation it deemed desirable to the Universidad Autonoma and the student, to use an American institution as the central repository for such an evaluation in the event it might prove to be necessary in subsequent years. It was felt that the interest of the United States public might not be fully protected if the student and the Universidad Autonoma were the only custodians of the evaluation.

(8) Recognizing that such a program would require some expenditure of effort or money, or both, by the medical school, it is suggested that the medical school might charge the student an appropriate fee. It is generally agreed, in view of the informal nature of the arrangement between the student and the medical school and the uncertainty regarding legal relationships, that tuition should not be charged without careful consideration of the legal implications.



(9) In order to emphasize the educational nature of the experience for the student and to clearly differentiate the experience from an externship, it is recommended that the hospital not be permitted to remunerate the student and that the student not be permitted to accept any remuneration for his services either from the hospital or from staff physicians.

GRL:kc  
4/8/71

Revised  
5/26/71  
HCN:ltw

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UNDERGRADUATE MEDICAL EDUCATION

AREA CODE 312  
527-1500



**JOINT MEETING  
OF  
COUNCIL OF DEANS  
COUNCIL OF ACADEMIC SOCIETIES**

Friday, February 4, 1972  
Palmer House Hotel  
Chicago, Illinois

9:00 am - 12:30 pm  
Monroe Ballroom

SELECTION PROCESSES FOR MEDICINE:  
ARE CURRENT POLICIES RATIONAL?

CURRENT CONCEPTS OF A THREE-YEAR CURRICULA

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

One Dupont Circle

Washington, D.C.

SELECTION PROCESSES FOR MEDICINE:  
ARE CURRENT POLICIES RATIONAL?

Moderator: Dr. Paul A. Marks

Discussant: Dr. Sam L. Clark, Jr.

Panelists: Mr. Martin S. Begun  
Dr. Paul R. Elliott  
Dr. Roy K. Jarecky  
Mr. Mark L. Rosenberg  
Dr. Harold J. Simon

## PROLOGUE

Associate deans and committees on admissions stand guard over the threshold to medicine. They are being pressed increasingly from every side; by ever-increasing numbers of applicants, by minority groups, by those who see admissions as the key to correcting the maldistribution of doctors, by politicians promoting individual constituents, by their own faculty colleagues with individual axes to grind. These pressures tend to be not just competitive, but mutually exclusive; preferential selection from minority groups becomes racial discrimination in reverse; lawsuits by disappointed applicants may force selection committees toward more exclusive use of objective criteria--a process that will intensify the degree to which medical school classes fail to represent the breadth of American society.

What should be the goals of the selection process? Should we continue to select only those for whom the academic challenge of medical school is only a little more of what they are already highly adapted to? Should we select humane, sensitive, warm and generous individuals? How? Lacking a definition of a "good doctor", can we rationally select at all? Or should the selection process be abandoned altogether for "open admission" followed by periodic weeding out?

Neither the pressures nor the goals nor the alternatives generally proposed seem rational. Can the selection of people to enter medical school be made rational? Perhaps not. The purpose of this discussion will be to explore the implications of these questions.

Sam L. Clark, Jr., M.D.  
Chairman, Dept. of Anatomy  
University of Massachusetts  
School of Medicine

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Division of Student Affairs

Estimated Increase in Undergraduate Students  
Describing Themselves As "Premedical"

We have attempted to ascertain whether or not there has been a substantial increase in the number of undergraduates describing themselves as premedical by comparing 1970-71 enrollment estimates with those for 1971-72.

Questionnaire Results

Two hundred seventy colleges and universities were contacted. Of the 115 institutions responding, about 60 provided usable data. Securing a clean count is difficult for a variety of reasons. A number of schools keep no tally of premedical students at all, a few record only those students who actually apply to medical school, while others either have no premedical major as such or are organized in a manner that does not allow for easy identification of those students in a particular professional preparation course sequence. Most premedical advisors did comment that they thought there were more premedical freshmen this academic year as compared to last and estimated the enlargement at 15% to 20%. The reasons provided to explain the increase included publicity related to the purported physician shortage, lack of jobs in the "hard" sciences, and the student's view of medicine as a service profession allowing for individual expression.

The data presented below is an approximation and should be utilized cautiously at best. As of December 16, 1971, schools with usable data reported an increase in premedical students as follows:

<u>Class</u>	<u>Percent Increase 1970-71 to 1971-72</u>
Freshmen	17
Seniors	16
All Four Years	20

A slight increase in minority students and at some universities a substantial increase in female premedical students seems also to have occurred.

American Council on Education Data

The American Council on Education's Office of Research reports that 17% more undergraduate freshmen identified themselves as potentially premedical or pre dental students in the fall of 1970 than in 1969. Another way to express this increase is to note that in 1969 3.3% of the total freshmen class described themselves as premedical or pre dental, whereas in 1970 3.9% so identified themselves. By 1971 this percentage had risen to 4.4% which represents a premedical-pre dental group 14% larger than that for the previous year. The freshmen premedical student gain of 17% derived from the questionnaire survey is thus only three percentage points different from that estimated in the ACE reports.\*

Comparison Graph

The graph appended to this report pictures the increase in the number of freshmen describing themselves as premedical or pre dental over a period of five years during which the over-all number of college freshmen appears to be levelling off. The number of medical school applicants has also steadily increased during the past few years. Even though fewer freshmen identified themselves as premedical in 1968 and 1969, it appears that the number of applicants for the classes entering 1972 and 1973 will not decrease. As noted above, a lack of employment opportunities in the natural sciences and engineering, the publicized need for physicians, and the attractiveness of medicine as a profession have boosted the number of applicants. However, it should also be kept in mind that the rejection of thousands of applicants each year may dampen the enthusiasm of students for medicine and result in a sharp slump in the number of applicants. Many schools are already suggesting that applicants with GPAs below 3 have little chance for success. Thus, the upward curves on the graph should not be taken literally since there are many factors, as yet unclear or unidentified, that soon may produce changes in the current directions of the plots.

\*National Norms for Entering College Freshmen - Fall 1971, 1970, 1969. American Council on Education, (1971 report in press), Vol. 5, No. 6, 1970; Vol. 4, No. 7, 1969.

January 7, 1972

Comparison of Numbers of Entering Freshmen, Freshmen Identifying Themselves as Premedical or Predental, and Applicants to Medical School, 1966-1971

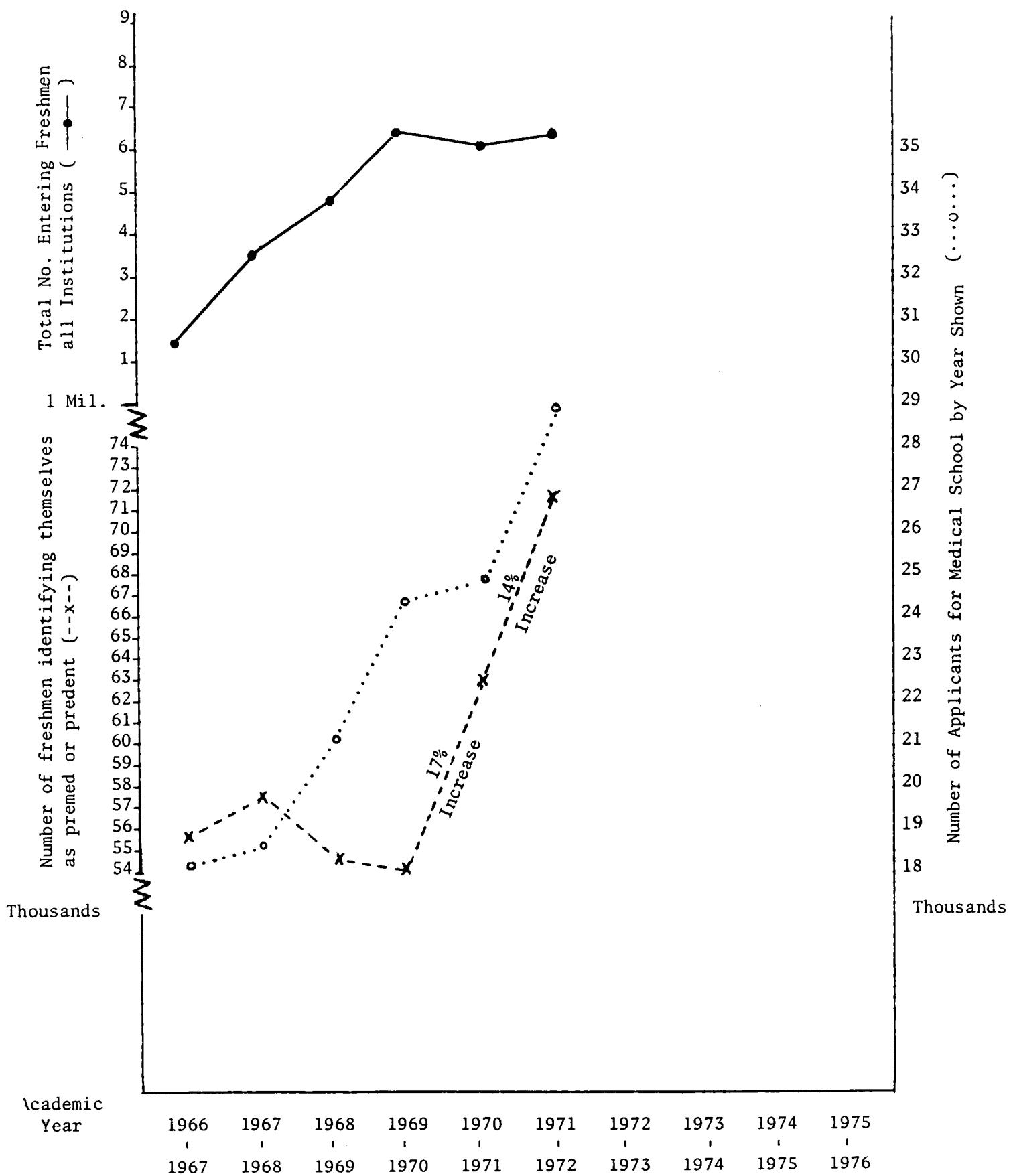


TABLE 1

Trends in Characteristics of MCAT Examinee Population 1965-71

The following table shows the percentages of examinees in various categories for each of the years 1965 through 1971.

<u>Characteristic</u>	<u>Percentages of Examinees</u>						
	<u>1965</u>	<u>1966</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971</u>
SEX:							
Male	90	89	89	89	88	86	84
Female	10	11	11	11	12	14	16
COLLEGE STATUS:							
Sophomore	4	5	4	4	4	3	3
Junior	43	44	46	45	44	44	39
Senior	36	35	34	35	35	30	30
College Graduate	17	15	16	15	17	22	27
UNDERGRADUATE MAJOR:							
Biological Sciences	43	45	46	48	48	49	48
Humanities, languages, the arts	7	6	6	6	5	5	4
Physical sciences and mathematics	17	17	18	18	18	25	23
Social Sciences	9	8	9	9	10	9	9
Premedical	18	17	15	12	12	6	5
Other	7	6	7	6	6	7	10

The number of examinees remained near 19,000 for the years 1962-65, then increased to 19,705 in 1966, 22,288 in 1967, 26,539 in 1968, 28,880 in 1969, 33,869 in 1970, and 45,324 in 1971.

SEX: There is a consistent increase in the percent of female examinees which is even more significant considering the major increase in total examinees thru the years.

COLLEGE STATUS: Note the rather sharp declines in percent of seniors in 1970 and percent of juniors in 1971 taking the test with the accompanying proportionate increases in percent of college graduates for each of these years. This suggests a significant increase among college graduates with an initial interest in medicine.

UNDERGRADUATE MAJOR: Outside of the substantial decrease in general premedical as a declared undergraduate major with a corresponding increase in the physical sciences and mathematics in 1970, there seems to be no other noteworthy change in this category.

Though the huge increase in MCAT examinations administered in 1971 is by no means accounted for by a corresponding increase in those retaking the test, the latter do account for substantial proportions of the total data presented in the previous table and is thus specified in more detail in Table 2.



TABLE 2

Comparison of Percentages of Non-Repeating and Repeating  
MCAT Examinees for 1970 and 1971

1970 - Repeating examinees were 21% of total examinee group  
1971 - Repeating examinees were 23.4% of total examinee group

<u>Characteristic</u>	<u>Non-Repeating Examinees</u>		<u>Repeating Examinees</u>	
	<u>1970</u>	<u>1971</u>	<u>1970</u>	<u>1971</u>
SEX:				
Male	86	83	89	86
Female	<u>14</u>	<u>17</u>	<u>11</u>	<u>14</u>
TOTAL	100	100	100	100
COLLEGE STATUS:				
Sophomore	4	4	0	0
Junior	53	49	10	8
Senior	25	24	51	51
College Graduates	<u>18</u>	<u>22</u>	<u>40</u>	<u>42</u>
TOTAL	100	99*	101*	101*
UNDERGRADUATE MAJOR:				
Biological Sciences	47	46	54	54
Humanities, languages, the arts	5	5	6	4
Physical sciences and mathematics	26	24	21	19
Social Sciences	9	9	8	9
Premedical	7	6	6	5
Other	<u>7</u>	<u>10</u>	<u>5</u>	<u>9</u>
TOTAL	101*	100	100	100

\*Percentages may not add to 100 because of rounding.

SEX: Note here not only an increase of 3% new female examinees but also a similar increase among women repeating the test, perhaps reflecting their perception of improved chances of eventual admission.

COLLEGE STATUS: The nature of the admission time-table explains both the concentration of examinees among the juniors and beyond and also why the majority of repeaters are seniors and college graduates. As noted with Table 1, a sharp increase in new MCAT examinees is observed among college graduates.

UNDERGRADUATE MAJOR: The most persistent MCAT examinees tend to be those with majors in the biological and physical sciences as might be expected.

DATAGRAM (for February 1972)

U.S. Medical Student Enrollments  
1968-1969 through 1971-1972

A higher than predicted first year enrollment\* in the nation's 108 medical schools for the 1971-1972 academic year was achieved mainly by the continuing enlargement of entering classes in previously existing medical schools and the creation of freshman classes in six new medical schools.

An AAMC survey of 1971 fall enrollments showed that totals for the 1971-1972 entering class, the largest freshman class ever admitted, amounted to 12,361, an increase of 1,013, or 8.9 percent over 1970. This gain equals the percentage increase recorded in 1970 over 1969; but when the component parts of the whole class are analyzed, important differences become apparent. Members of minority segments, for instance, now claim 10.3 percent of the freshman class in comparison with 8.8 percent in 1970, 6.1 percent in 1969, and only 4.2 percent in 1968 (Figure 1).

Black Americans, the largest minority group, account for 881, or 7.1 percent, of the entering class students. Although this total falls somewhat short of the 1,000 black freshmen targeted for 1971 by an AAMC Task Force\*\*, the consistent upward trend from 266 in 1968 to 881 in 1971 establishes a gain of 615, or 231.2 percent, since 1968 and reflects successful recruitment efforts (Figure 3). Admissions of non-U.S. blacks have been variable; 39 in 1968, 48 in 1969, 87 in 1970, and 57 in 1971 (Table 2).

\*The total predicted first year enrollment for 1971 was 12,150.  
Expansion of First Year Enrollment: Medical Schools' Current Plans for Next Year's Entrants. Datagram. J. Med. Educ., 46:1004-1006, 1971.

\*\*"Report of the Association of American Medical Colleges Task Force to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students." Washington, D.C.: Association of American Medical Colleges, April 1970.

Other minority segments in first-year classes increased more slowly from 147 in 1968, 201 in 1969, and 301 in 1970 to 394 in 1971 (Figure 3). These totals are lower than those published previously<sup>+</sup> because the entire first year class of the University of Puerto Rico School of Medicine at San Juan has been deleted from the minority counts in the AAMC study. Thus, only 40 students of Puerto Rican ethnic descent who reside in the continental United States entered a U.S. medical school in 1971. These 40 mainland Puerto Ricans, however, represent a gain of 48.2 percent over 1970. Mexican American freshmen achieved a 60.3 percent rise over 1970; and American Orientals increased by 13.2 percent, while a 100 percent gain was attained by the 22 first-year American Indians (Table 2).

Women medical students comprised 1,673, or 13.5 percent, of the 1971 freshman class, a gain of 417, or 33.2 percent, over 1970. This surpassed the dramatic increase of 32.5 percent in 1970 over 1969 and accomplished a startling rise of 786, or 88.6 percent, over 1968 (Table 1 and Figure 2). In contrast, the increase percentage over the previous year for men entrants declined from 6.5 percent in 1970 to 5.9 percent in 1971.

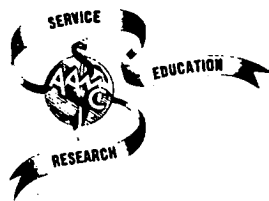
Women of minority groups are responsible for rather high percentages within their own groups: American Indian women - 8, or 36 percent; American black women - 200, or 23 percent; American Oriental women - 43, or 20 percent; non-U.S. women - 31, or 17 percent; and Mexican American women - 10, or 12 percent.

<sup>+</sup>U.S. Medical Student Enrollments, 1968 through 1970-1971. Datagram. J. Med. Educ., 46:96-97, 1971.

Respondents to the 1971 fall enrollment survey also reported a total of 43,399 medical students - comprising all groups and all years. This represents an increase of 3,161, or 7.9 percent, over 1970. Of this overall total, 4,690 (10.8 percent) are women, 2,056 (4.7 percent) are black Americans, 1,004 (2.3 percent) belong to other U.S. minority groups, and 514 (1.18 percent) come from foreign countries. In comparison with 1970, all of these groups showed significant increases with the exception of foreign students (Tables 3 and 4).

In summary, for both women and minority medical students larger increases in the 1971-72 first-year class were recorded than for either the first-year class as a whole or the entire medical school enrollment for the 1971-1972 academic year.

Office of Student Records  
AAMC Division of Student Affairs



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
 SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

DIVISION OF STUDENT AFFAIRS

TABLE I

U.S. MEDICAL SCHOOL ENROLLMENTS - MEN AND WOMEN

TOTAL FIRST - YEAR CLASS\*

	<u>1968-1969</u>		<u>1969-1970</u>		<u>1970-1971</u>		<u>1971-1972</u>		<u>Increase</u>	
	99 Schools		101 Schools		102 Schools		108 Schools			
	No.	%	No.	%	No.	%	No.	%	No.	%
MEN	8,976	91.0	9,474	90.9	10,092	88.9	10,688	86.5	596	5.9
WOMEN	887	9.0	948	9.1	1,256	11.1	1,673	13.5	417	33.2
TOTAL	9,863	100.0	10,422	100.0	11,348	100.0	12,361	100.0	1,013	8.9

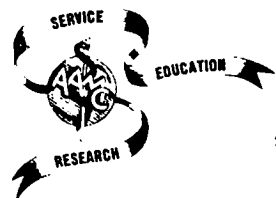
\*Including repeaters and those who re-entered

TABLE 2

ENROLLMENTS OF MAJOR MINORITY SEGMENTS AND FOREIGN STUDENTS

FIRST - YEAR CLASS

U.S. MINORITY GROUPS	<u>1968-1969</u>		<u>1969-1970</u>		<u>1970-1971</u>		<u>1971-1972</u>		<u>Increase</u>	
	No.	%	No.	%	No.	%	No.	%	No.	%
Black Americans	266	2.70	440	4.22	697	6.14	881	7.12	184	26.4
American Indians	3	.03	7	.07	11	.10	22	.18	11	100.0
Mexican Americans	20	.20	44	.42	73	.64	117	.95	44	60.3
American Orientals	121	1.23	140	1.34	190	1.67	215	1.74	25	13.2
Puerto Ricans-Mainland	3	.03	10	.10	27	.24	40	.32	13	48.2
TOTAL	413	4.19	641	6.15	998	8.79	1,275	10.31	277	27.8
FOREIGN STUDENTS										
Non U.S. Blacks	39	.40	48	.46	87	.77	57	.46	-30	-34.5
Others	82	.83	109	1.05	126	1.11	128	1.04	2	1.6
TOTAL	121	1.23	157	1.51	213	1.88	185	1.50	-28	-13.2



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
 SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

DIVISION OF STUDENT AFFAIRS

TABLE 3

U.S. MEDICAL SCHOOL ENROLLMENTS - MEN AND WOMEN

TOTAL ENROLLMENT\*

	<u>1968-1969</u> 99 Schools		<u>1969-1970</u> 101 Schools		<u>1970-1971</u> 102 Schools		<u>1971-1972</u> 108 Schools		<u>Increase</u>	
	No.	%	No.	%	No.	%	No.	%	No.	%
MEN	32,697	91.2	34,298	91.0	36,360	90.4	38,709	89.2	2,349	6.5
WOMEN	3,136	8.8	3,392	9.0	3,878	9.6	4,690	10.8	812	21.0
TOTAL	35,833	100.0	37,690	100.0	40,238	100.0	43,399	100.0	3,161	7.9

\*Including repeaters and those who re-entered

TABLE 4

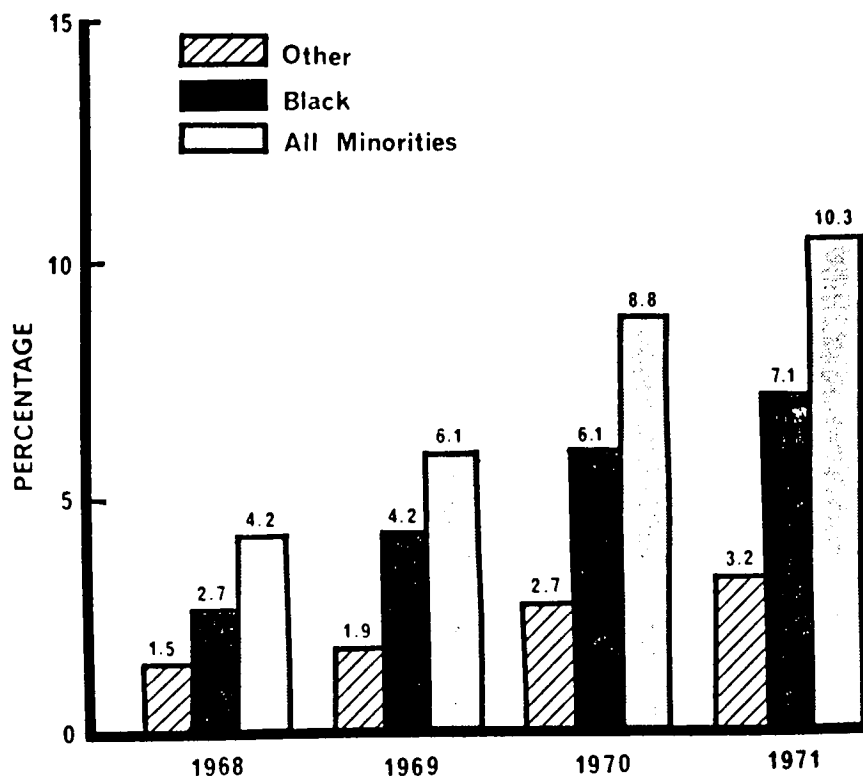
ENROLLMENTS OF MAJOR MINORITY SEGMENTS AND FOREIGN STUDENTS

TOTAL ENROLLMENT

U.S. MINORITY GROUPS	<u>1968-1969</u>		<u>1969-1970</u>		<u>1970-1971</u>		<u>1971-1972</u>		<u>Increase</u>	
	No.	%	No.	%	No.	%	No.	%	No.	%
Black Americans	783	2.19	1,042	2.76	1,509	3.75	2,056	4.74	547	36.3
American Indians	9	.03	18	.05	18	.04	35	.08	17	94.4
Mexican Americans	59	.16	92	.25	148	.37	247	.57	99	66.9
American Orientals	421	1.17	452	1.19	571	1.42	646	1.48	75	13.1
Puerto Ricans-Mainland	3	.01	26	.07	48	.12	76	.18	28	58.3
TOTAL	1,275	3.56	1,630	4.32	2,294	5.70	3,060	7.05	766	33.4
FOREIGN STUDENTS										
Non U.S. Blacks	154	.43	130	.34	180	.45	212	.49	32	17.8
Others	357	1.00	442	1.17	470	1.17	302	.70	-168	-35.7
TOTAL	511	1.43	572	1.51	650	1.62	514	1.18	-136	-20.9

FIGURE 1

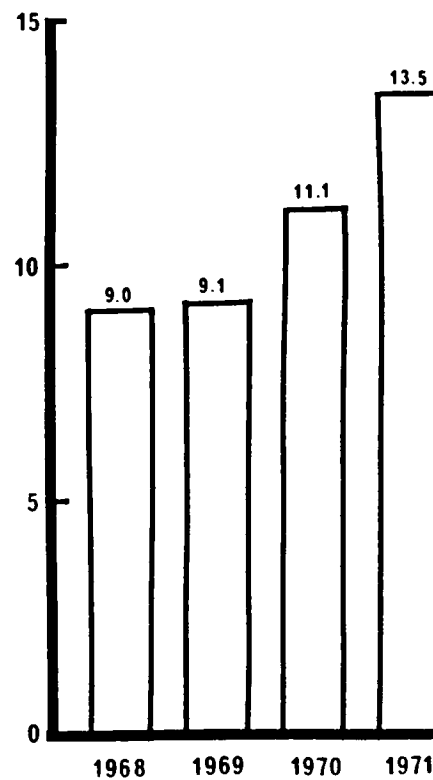
MINORITY REPRESENTATION IN FIRST YEAR CLASSES OF U.S. MEDICAL SCHOOLS 1968-69 THROUGH 1971-72



Footnote for Figure 1  
 All percentages exclude non-U.S. Citizens  
 Other=American Indian, Mexican American,  
 American Orientals, Puerto Ricans-Mainland

FIGURE 2

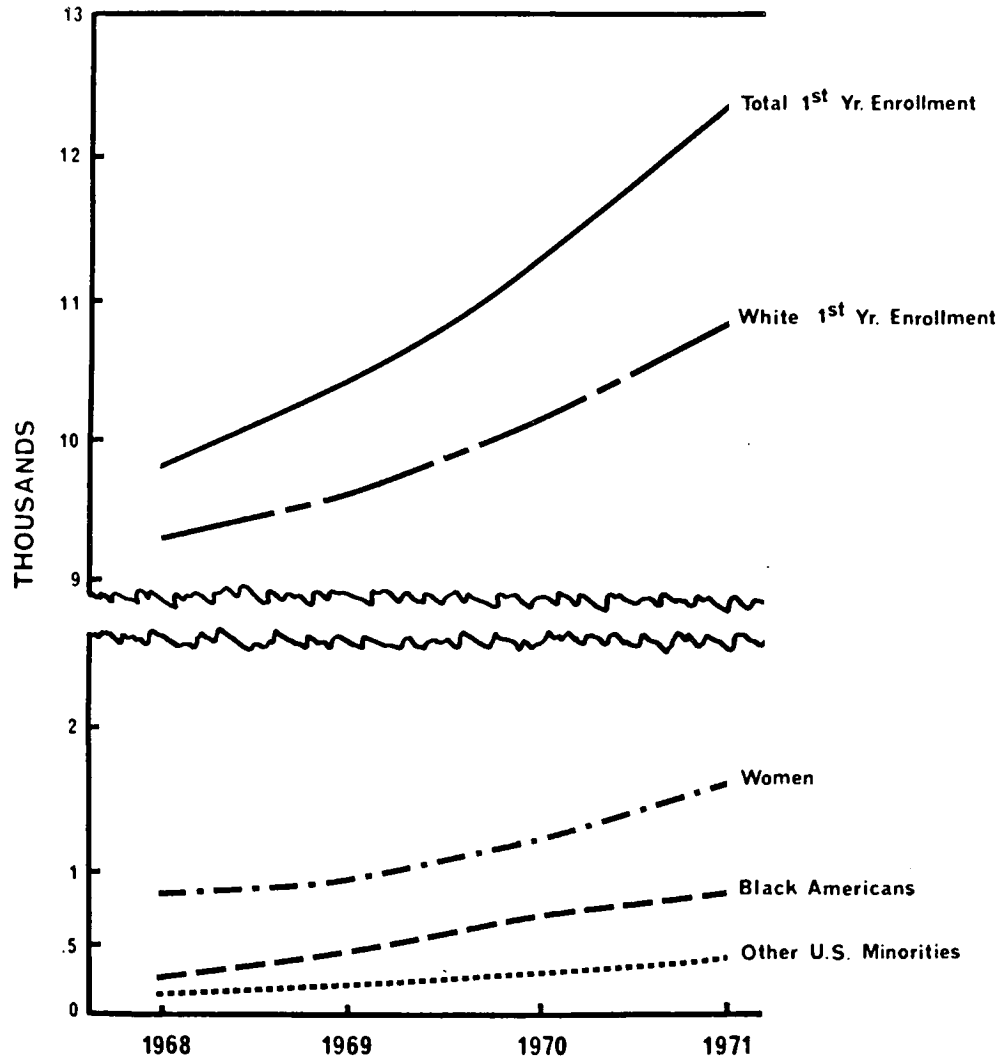
REPRESENTATION OF WOMEN IN FIRST YEAR CLASSES OF U.S. MEDICAL SCHOOLS 1968-69 THROUGH 1971-72



Footnote for Figure 2  
 Percentages include Minority Women and Foreign Nationals

FIGURE 3

NUMBER OF FIRST YEAR U.S. MEDICAL STUDENTS  
1968-69 THROUGH 1971-72





ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
Division of Student Affairs

Summary of Admissions Lawsuit Survey of December, 1971

A. Sample

	<u>No.</u>	<u>%</u>
1. U.S. Medical Schools polled#	115	100
2. Replies received (as of 2/6/72)	98	85

B. Results

1. To what extent has your medical school been faced with legal action concerning your admissions process during the past five years?

Approximate Number of Lawsuits

<u>Year</u>	<u>Initiated</u>	<u>Threatened</u>	<u>Actual</u>
1967		<u>1</u>	<u>0</u>
1968		<u>1</u>	<u>0</u>
1969		<u>2</u>	<u>1</u>
1970		<u>3</u>	<u>1</u>
1971		<u>6</u>	<u>3</u>
Total		<u>13</u>	<u>5</u>

Definitions

Threatened = School contacted by lawyer who threatened to sue on behalf of an applicant.

Actual = Lawsuit actually initiated against school.

2. If your school had any actual or threatened admissions lawsuits during the past five years, please indicate their nature below:

<u>Nature of Lawsuit</u>	<u>Approximate Number</u>	
	<u>Threatened</u>	<u>Actual</u>
a) Residency (e.g. issue of state residency as criterion for acceptance)	<u>3</u>	<u>0</u>
b) Sex (e.g. issue of sex discrimination bias)	<u>1</u>	<u>1</u> (also h)
c) Race (e.g. issue of race discrimination bias)	<u>6</u>	<u>2</u>
d) Age (e.g. issue of age discrimination bias)	<u>0</u>	<u>0</u>
e) Health (e.g. issue of physical or emotional health as criterion for acceptance)	<u>1</u>	<u>1</u>
f) Late application	<u>1</u>	<u>0</u>
g) False credentials	<u>1</u>	<u>0</u>
h) 14th Amendment*	<u>1</u>	<u>1</u> (also b)
TOTAL	<u>14</u>	<u>4</u> individuals

\*14th Amendment (Section 1) - "All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

#Including seven developing schools that had no applicants as of 1971.

DGJ/sg

W#8240

SELECTED BIBLIOGRAPHY ON THE ADMISSIONS PROCESS

American Medical Association, "Education Number" Journal of the American Medical Association, published the third week in November each year.

This is a comprehensive review of medical education compiled annually. All schools and new developments are reviewed. Varied data on students is included. This a valuable reference for all medical educators.

Dube, W.F., Stritter, Frank T., Nelson, Bonnie C., "Study of U.S. Medical School Applicants, 1970-71" J. Med. Educ., 46:837-857, 1971.

This study is the latest in a series of annual applicant studies, produced by the applicant activity for a specific entering year. In the more recent studies, comparison and trend data are listed chronologically for the past ten years.

Erdmann, J.B., Mattson, D.E., Hutton, J.G., Jr., and Wallace, W.L. "The Medical College Admission Test: Past, Present, and Future" J. Med. Educ., 46:937-946, 1971.

An exposition of the historical development of the test with its supporting rationale, its current characteristics and usage, and projections for future modification.

Funkenstein, D.H., "Current Medical School Admissions: The Problems and a Proposal" J. Med. Educ., 45:7, 497-509, 1970.

The following are problems cited by medical school admissions committees:

1. A marked increase in number of applicants.
2. Development of new programs without a concomitant increase in the size of the entering class.
3. Change in preparation, career plans, and values of medical school applicants.

As one aspect of a proposal to help solve these problems, the author suggests an admissions committee including subcommittees for each individual program offered at the school.

Gough, H.G., "Nonintellectual Factors in the Selection and Evaluation of Medical Students" J. Med. Educ., 42:642-650, 1967.

A suggestion that there are other factors besides intellectual ability and academic achievement to consider in the selection of medical students and a recommendation that medicine needs many different types of students.

Hamberg, R.L., Swanson, A.G., and Dohner, C.W. "Perceptions and Usage of Predictive Data for Medical School Admissions" J. Med. Educ., 46:959-963, 1971.

A survey of admissions officers and pre-medical advisors on some seventeen possible selection criteria reveals remarkable agreement between the two groups and also identifies the most "useful" and "strong" criteria.

Johnson, D.G. and Hutchins, E.B., "Doctor or Dropout?: A Study of Medical Student Attrition" J. Med. Educ., 41:1099-1269, 1966.

This special issue of the JME reports a national study of the medical student dropout problem. Data for the study are drawn from the following sources: (a) central AAMC records on over 108,000 medical school entrants from 1949 through 1962; (b) over 4,000 questionnaires filled out by medical school deans, admissions officers, and student affairs officers, and by 1961-62 dropouts, repeaters, and successful students; and (c) site visits during 1962 and 1963 to twenty medical schools to interview almost 300 students, dropouts, faculty members, and administrative officers. The report includes detailed suggestions for reducing attrition.

Mason, Henry R. and Ruhe, W., "Students Transferring from Foreign to U.S. Medical Schools in Advanced Standing" J. Med. Educ., 44:561-570, 1969.

A review of the experiences with and evaluation of the performance of American and foreign medical students transferring from foreign to U.S. schools with advanced standing. The most valid measure for predicting future academic success of such transfers appeared to be Part I of the National Board examination. A centralized application service for screening such transfer applicants is suggested to facilitate the procedure.

Page, R.G. and Littlemeyer, M.H., Preparation for the Study of Medicine, Chicago: University of Chicago Press, 1969.

A series of papers presented at the 1967 AAMC-University of Chicago sponsored conference to consider educational trends and their implications in preparing students for medical school. Much helpful information is presented, part of which was collected in questionnaires answered by both students and officials at medical schools.

Sedlacek, W.E. (Ed.), Medical College Admission Test Handbook for Admissions Committees, (2nd ed.) Evanston, Ill.: Association of American Medical Colleges, 1967.

Though no longer in print, multiple copies were distributed to each medical school admissions office. This handbook discusses the usual reliability and validity issues of the test and provides a summary of recent research as well as suggestions for the use and interpretation of test results.

CURRENT CONCEPTS OF A THREE-YEAR CURRICULA

Moderator: Dr. Daniel C. Tosteson

Discussant: Dr. Carleton B. Chapman

Panelists: Dr. L. Thompson Bowles  
Dr. Ernst Knobil  
Dr. Sherman M. Mellinkoff  
Dr. Robert G. Page  
Dr. Robert E. Sandstrom

January 4, 1972

A three-year sequence leading in medical schools to the M.D. degree is well worth considering for many reasons. For one thing, medical educators have wondered for years how best to utilize the fourth year of the traditional sequence, but until recently, very few were willing to consider the logical step of eliminating it altogether.

The most compelling reason for adopting a three-year curriculum for most (but definitely not all) candidates for the M.D. degree is that the four-year curriculum is today an anachronism and something of a historical accident. Its original purpose - to train the complete practitioner - was grossly modified with the development of internship and residency programs. But the logical implications of such developments have never been taken fully into account by curriculum planners in medical schools. What is needed today is critical consideration of sequence and repetition in the curriculum, as well as (or even more than) content. But the building of the M.D. curriculum by mindless accretion and worship of the number four is hardly defensible.

When all is said and done, what is needed is a loosening up of the system so that some students (and probably most of them) will receive the M.D. three years after entering medical school. Others may, for good academic reason or by preference, take four. Still others may remain in the pre-M.D. status even longer.

But insistence on four years as the only permissible sequence is no longer justifiable.

Carleton B. Chapman, M.D.  
Dean, Dartmouth Medical School

	Year Started	Regular Program or optional	How Long	Method of Acceleration
ALABAMA	1971	0	36 months	Core basic science. Begin in July. No major vacations in summers.
ALBERT EINSTEIN	1971	R	36 months	Five months of vacation (including summers) and four months of electives have been dropped.
BAYLOR	1970	R	36 months	No summer vacation. Program includes 3 months of electives.
UC IRVINE	1970	0	12 quarters (33 months)	Dropped summer vacations and two electives.
UC SAN FRANCISCO	1969	0	12 quarters (36 months)	Dropped all summer vacations.
DARTMOUTH	1970	0	128 weeks (33 months)	Dropped all summer vacations.
DUKE	Several Years	0	39 months	Drop summer vacation after 2nd and 3rd years.
INDIANA	1968	0	39 months	Drop summer vacation after the 2nd and 3rd years.
LOYOLA	Several Years	0	39 months	By going summers after the 2nd and 3rd years.
KANSAS	1969	0	39 months	Dropping summer vacations.
MEHARRY	1970	0	39 months	By going in the summers after the 2nd and 3rd years.
MINNESOTA	1969	0	33 months	Drop summer vacation plus 2 electives.
NEBRASKA	1970	0	36 months	No summer vacation. Drop 6 weeks of electives.

	Year Started	Regular Program or optional	How Long	Method of Acceleration
NORTH CAROLINA	1967	0	32 months	Going summers and taking electives in the afternoon during the first year.
TOLEDO OHIO	1969	R	2 yrs. 9 months (132 weeks)	Core basic science, core clerkships & electives. 13 weeks vacation for the whole program.
OHIO STATE	1970	R	3 calendar yrs.	Begin July of entering year. Core integrated basic science. Go straight through summers.
PENNSYLVANIA	1968	0	32 months	Go summers after 1st and 2nd years.
RUSH	1971	0	34 months	Drop summer holidays.
SOUTH CAROLINA	1971	0	33 months	Enter in advanced standing by passing some basic science & dropping some electives.
STANFORD	Many Years	0	39 months	Drop summer vacations.
SUNY SYRACUSE	1970	0	33 months	By entering in advanced standing. Curriculum is the same for 3 and 4 year students but summer vacations are dropped for 3 year students.
TENNESSEE	1943	R	36 months	18 months of basic science plus 18 months clinical clerkship.
UT HOUSTON	1971	R	36 months	12 quarters, final two electives. Go all summers.
UT GALVESTON	1970	0	33 months	Two years basic science followed by 48 weeks of required clerkships. Students must pass Part II of the National Boards and obtain an approved internship. Drop senior electives.
MCV	1968	0	33 months	Begin 3rd year in July and skip senior electives. Must pass Parts I & II of National Boards & get an internship.
UW SEATTLE	1967	0	10 quarters	Begin third year in July to take one year of elective clerkships.

In addition to the above information, it is of interest that no school on the list has yet encountered or anticipates major licensure problems for graduates.

The regular program of 6 of the listed 26 medical schools is three calendar years. In these 6 schools, students who go for longer periods require special programs.

Twenty schools give options to students to accelerate and graduate in under 4 years. The percentage of students opting for the accelerated programs varies from as high as 80% to as low as 1.2%. Twenty of the 26 schools permit fulfillment of requirements in 36 months or less. Twelve schools offer complete requirements in 34 months or less and eleven of these schools offer complete requirements in thirty-three months or less.

In the 20 schools giving the option for an accelerated program, students are self-selected or offered the option by the school on the basis of academic standing. In none of these schools is the student required to accelerate, and in all cases of student self-selection specific requirements must be satisfied.

All accelerated programs require a diminution in traditional vacation time. Every school listed has dropped one or more summer vacations, though other holiday periods are not significantly altered. Four schools have dropped electives. Five schools indicate a definite contraction in the content of traditionally-required basic science. Two schools allow time conservation by entering first year students into advanced standing. Generally, traditional course content is not altered. Acceleration has been achieved, in large part, by the combined sacrifice of vacations and/or electives (26 schools).

One three-year program has been operating continuously since 1943 (Tennessee), three have been in existence for many years, two since 1967, three since 1968, three since 1969, eight since 1970 and five began in 1971.



#### SUGGESTED ARTICLES

1. Blumberg, M.S. Accelerated Programs of Medical Education. J. Med. Educ., 46:643, 1971.
2. Page, R. G. The Three-Year Medical Curriculum. J.A.M.A., 213:1012, 1970.
3. Stetten, D., Jr. Projected Changes in Medical School Curriculum. Science, 174:1303, 1971.
4. Swanson, A.G. The Three-Year Medical School Curriculum. (Editorial.) J. Med. Educ., 47:67, 1972.

[Notes and  
Attachments]

NOTES  
ON  
JOINT MEETING

COUNCIL OF DEANS

and

COUNCIL OF ACADEMIC SOCIETIES

February 4, 1972

Palmer House Hotel  
Chicago, Illinois

9:00 a.m. - 12:30 p.m.

An estimated 300 persons were assembled in the first joint meeting of the Council of Deans and the Council of Academic Societies.

The first half of the program dealt with the question, "Selection Processes for Medicine: Are Current Policies Rational?" Dr. Paul A. Marks was moderator and CAS Chairman, Dr. Sam L. Clark, Jr., discussant. A copy of Dr. Clark's provocative paper (Attachment A) set the stage for a vigorous discussion of the audience with the panelists: Mr. Martin S. Begun, Dr. Paul R. Elliott, Dr. Roy K. Jarecky, Mr. Mark L. Rosenberg, and Dr. Harold J. Simon.

In general Dr. Clark described the admissions process as a "nightmare" for the applicant and for the admissions committee. He said the educational goals need to be reexamined in terms of how we wish doctors to behave. We need to be able to test competence as well as knowledge and then redesign the selection procedures.

Mr. Begun: Cited the cost of the interview to the student. If each interview cost the applicant \$100.00, the total cost for one class would be

\$2 million; this would not include faculty time, which might cost an additional \$15-20 million per year. Should set up a regional interview system for medical school applicants.

Dr. Hoffman (Audience): Publicity on the doctor shortage should be accompanied by an announcement that medical schools do not lack applicants. He worries about the increasing number of applications per applicant. Schools could agree to a maximum number of schools (10 was suggested) to which applicants could apply and use clearinghouse mechanism.

Dr. Elliott: Is the selection process being done by the wrong people at the wrong time? Perhaps admissions should be done at the sophomore or junior undergraduate level.

Dr. Simon: Thinks bringing premed advisers and medical school admissions officers together, as AAMC has, is fruitful.

Mr. Rosenberg: Schools need to define the problem, examine objectives, examine alternatives, and choose the alternative that best solves the problem; state goals and choose strategies for selection to accomplish those goals. He estimates that the cost to the school of selecting one medical student is \$1,200.00.

Recommends preliminary screening of applications. Also, notify applicants of actual admission criteria. (If you don't take students under a "B" average, tell them.) Finally, follow-up of what becomes to students to the admissions committees so that they could benefit in the selection process in the future.

Dr. Jarecky: Schools need to say the type of student they will consider. If out-of-state restrictions are real, say so. Schools need to better use pre-medical advisers. The premedical advisers are in a better position to help the student if they know what the medical school wants. Finally, the medical school

should be open and direct with the public about the true situation.

Dr. Gelhorn (Dean, Pennsylvania): One advantage from the interview might be to help the applicant evaluate the school.

Mr. Rosenberg: There should be alternate recruitment methods that would be less expense and still permit the applicant to evaluate the school.

Dr. Davis Johnson (AAMC): The average number of applications filed through AMCAS is six, which is the same as last year. In AMCAS schools providing more precise descriptive statements, the number of applications were reduced. An estimated \$25,000 - \$35,000 savings per school has accrued to AMCAS schools. Many schools are passing the saving on to the student.

Dr. Rosenholtz (Assoc. Dean, Univ. of Missouri): He takes letters of recommendation on applicants from medical students. These result in more realistic appraisals (less "BS"). Schools need to define objectives in terms of what is a good physician, rather than in terms of what is a good applicant.

Dr. Tupper (Dean, Univ. of California-San Diego): The historical record of admissions dating from the late 1940s is one of success. (We need more "lab tests before we operate.")

Dr. Keith (Premed Adviser, Bucknell): Premed advisers need to have a profile of the medical school class. Limiting the number of applications would put a tremendous burden on the premed adviser.

Dr. Hoffman (Audience): He thinks AMCAS fee schedule has resulted in an average of six applications.

Dr. Fishman (Assoc. Dean, Univ. of Chicago): Faculty must be involved in admissions even if it is expensive. Objectives should not be too clearly defined. He would be opposed to any national body defining the objectives of

any school.

North Carolina Participant: Thinks it important that applicants see the school and meet the students also. Suggests lottery.

Dr. McKee (Dean, West Virginia): West Virginia has been doing all of the things mentioned. West Virginia produces MDs for West Virginia, not for the nation, and their brochure says so.

The second session addressed the "Current Concepts of a Three-Year Curricula." Dr. Daniel C. Tosteson served as moderator. COD Chairman, Dr. Carleton B. Chapman, as discussant, opened the session by suggesting that the Carnegie Commission had made the right recommendation for the wrong reason by favoring the three-year curriculum and the three-year residency (See Attachment B). Dr. Chapman thinks the 3-3-3 sequence can become a reality.

Panelists were Dr. L. Thompson Bowles, Dr. Ernst Knobil, Dr. Sherman M. Mellinkoff, Dr. Robert G. Page, and Dr. Robert E. Sandstrom.

Dr. Mellinkoff: The Flexner Report urged the long-overdue reform of medical education. The model used was that of Hopkins. Modification of medical education should be done by the medical schools. They should proceed cautiously.

Dr. Felix (Dean, St. Louis): Notes in the data that 39 months is interpreted as a three-year program. In addition, if you eliminate the fourth year because it is an internship, and then eliminate the internship, you have a "double amputation."

Dr. Page: It is important to recognize the different ability levels of medical students.

Dr. Morgan (Assoc. Dean, Columbia Univ.): Objects to using fourth year

as "catch-up" time. Need to use this time for the gifted as well.

Participant (Audience): It is erroneous to assume that vacation time is used only for rest and recreation. It is often used by students in a broadening experience that will help them find their future place in medicine.

Attachment: 2

CAN THE SELECTION OF MEDICAL STUDENTS BE MADE RATIONAL?

THIS IS A POLEMIC. I WILL NOT TRY TO DOCUMENT MY CHARGES, BUT WILL LEAVE IT TO EACH OF YOU, FROM YOUR OWN EXPERIENCE, TO CONFIRM THE TRUTH OF WHAT I SAY - AS WELL AS TO RECOGNIZE THAT TRUTH HAS ANOTHER SIDE.

(ADMISSION TO MEDICAL SCHOOL HAS BECOME A NIGHTMARE FOR APPLICANTS AND ADMISSIONS COMMITTEES ALIKE. WITH MORE THAN TWICE AS MANY APPLICANTS AS PLACES IN MEDICAL SCHOOLS, COMPETITION HAS REACHED A FEVER PITCH THAT DESTROYS SCHOLARSHIP; PREMEDICAL STUDENTS WORK TO PLEASE THEIR TEACHERS, RATHER THAN TO PREPARE FOR MEDICINE.)

(FOR THE ASSOCIATE DEANS AND COMMITTEES WHO SELECT, THERE ARE PRESSURES FROM EVERY SIDE. INCREASING NUMBERS OF APPLICANTS, EACH MAKING MULTIPLE APPLICATIONS (ONE APOCRYPHAL STUDENT APPLIED TO 63 MEDICAL SCHOOLS), HAVE INCREASED THE WORK LOAD TO THE POINT WHERE NO ONE RECEIVES DELIBERATE CONSIDERATION. MEMBERS OF MINORITY GROUPS AND THEIR ADVOCATES PRESS FOR GREATER REPRESENTATION, CREATING SO-CALLED <sup>REVERSE</sup> DISCRIMINATION, WITH ITS GROWING AURORA OF LAWSUITS.) REFORMERS DISTURBED OVER THE MALDISTRIBUTION OF PHYSICIANS PUSH FOR GEOGRAPHICAL QUOTAS FOR MEDICAL STUDENTS. PUBLIC SUPPORT FOR MEDICAL EDUCATION BRINGS WITH IT THE PRESSURE FOR ADMISSIONS COMMITTEES TO SUBMIT TO THE IMPORTUNINGS OF POLITICAL PATRONAGE. THE AMA IS PRESSING FOR "PRACTISING PHYSICIANS" ON ADMISSIONS COMMITTEES, AS IF THE CLINICAL MEMBERS OF MEDICAL SCHOOL FACULTIES WERE NOT PRACTISING PHYSICIANS. EVEN THE COMMITTEE'S FACULTY PEERS -- FRIGHTENED BY THE INFORMATION EXPLOSION IN BIOMEDICAL SCIENCE -- EXERT PRESSURE AGAINST THE ADMISSION OF THE SCIENTIFICALLY UNSOPHISTICATED.

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( IN THE FACE OF THESE PRESSURES, HOW DO WE GO ABOUT SELECTING MEDICAL STUDENTS? FIRST WE MAKE OBIESSANCE TO THE MYSTICAL NUMEROLOGY OF GRADES AND MCAT SCORES, BECAUSE WE HAVE LEARNED THAT THEY IDENTIFY THE STUDENTS WHO CAN MEMORIZE FAST ENOUGH TO WITHSTAND THE INFORMATION OVERLOAD OF MEDICAL SCHOOL. ) IF THE GRADES AND MCAT SCORES ARE NOT CONSISTENT, WE TRUST THE MCAT SCORES -- BECAUSE THEY ARE GIVEN NATIONALLY AND ANALYSED STATISTICALLY -- TO TELL US EITHER THAT THE STUDENT IS SMART IN SPITE OF BEING LAZY, OR THAT THE STUDENT IS DUMB BUT THAT THE COLLEGE DOESN'T GRADE TOO HARD. ( WHEN THE MCAT TELLS US SOMETHING THAT WE DON'T WANT TO KNOW -- SUCH AS THAT A BLACK APPLICANT IS UNPREPARED BY WHITE, MIDDLE-CLASS STANDARDS -- WE IGNORE IT. )

WE PAY ATTENTION TO LETTERS OF RECOMMENDATION FROM COLLEGE PROFESSORS OR PREMEDICAL COMMITTEES, BUT ONLY LONG ENOUGH TO FIND THE VEILED STATEMENT THAT DISCLOSES WHERE THE APPLICANT RANKS AMONG PREMEDICAL STUDENTS, THUS CONFIRMING THE EVIDENCE OF THE NUMBERS. ALL OTHER THINGS BEING EQUAL, WE LOOK TO SEE IF THE APPLICANT HAS BROAD INTERESTS AND IS A NICE GUY.

WE SPEND THE EQUIVALENT OF A DEPARTMENT CHAIRMAN'S SALARY ON INTERVIEWS, AND ARGUE HEATEDLY OVER THE RESULTS -- TO WHAT PURPOSE? PURPORTEDLY TO EVALUATE SANITY, MOTIVATION AND THE ABILITY TO DEAL SENSITIVELY WITH OTHER PEOPLE. BUT THE QUESTION OF SANITY, IF IN DOUBT, USUALLY CAN NOT BE SETTLED WITHOUT ACCESS TO PRIVILEGED COMMUNICATIONS BETWEEN APPLICANT AND PSYCHIATRIST.



(WHEN IT COMES TO JUDGING MOTIVATION WE ARE INTOLERANT OF A SANE AND REALISTIC AMBIVALENCE, BUT ARE SUCKERS FOR THE GUNG-HO HOSPITAL HANGERS-ON AND THE CON ARTISTS.) AS FAR AS JUDGING THE APPLICANT'S HUMANITY IS CONCERNED, WE BEG OFF, BEING AFRAID TO JUDGE ON THE BASIS OF A BRIEF INTERVIEW. BY AND LARGE, IF WE CAN RECOGNIZE OURSELVES IN THE APPLICANT WE ARE FAVORABLY IMPRESSED. THERE IS LITTLE EVIDENCE THAT WE USE THE INTERVIEW EFFECTIVELY.

(WHY DO WE SELECT IN THIS FASHION? BECAUSE IT ASSURES A LOW ATTRITION RATE IN MEDICAL SCHOOL, AND BECAUSE IT IS MORE FUN TO TEACH BRIGHT APPLE-POLISHERS, WHOM WE RECOGNIZE AS SMART ENOUGH TO BE DOCTORS BECAUSE THEY QUICKLY AND ACCURATELY REGURGITATE WHAT WE PONTIFICATE FROM THE LECTURE PODIUM.)

(AND SO WHAT DO WE GET AS MEDICAL STUDENTS? MIDDLE-CLASS WHITE MALES, SEMI-LITERATE SCIENTISTS AND ANTI-SCIENTIFIC SELF-STYLED HUMANISTS. A GRAY, HOMOGENIOUS MASS OF COMPULSIVE OVER-ACHIEVERS, \*CONDITIONED ALL THEIR LIVES TO PERFORM FOR THE PRAISE OF OTHERS, RATHER THAN FOR THEIR OWN CURIOSITY AND SATISFACTION IN A JOB WELL DONE.)

(HOW DOES THIS SELECTION AFFECT OUR OUTPUT OF DOCTORS? GEARED AS THEY ARE TO EXTERNAL PRAISE, THEY SEEK PEER-GROUP REWARDS AMONG THE MEDICAL PROFESSION, ONLY TO FIND THAT A PHYSICIAN'S WORTH IS MEASURED IN THE MONEY HE MAKES. THEY BECOME ENTREPRENEURS, COMPETITIVE ACES WHO CAN NEITHER COLLABORATE IN NOR DELEGATE RESPONSIBILITY FOR THE CARE OF PATIENTS -- NO WONDER THERE IS NO SUCH THING YET AS A TRUE HEALTH-CARE TEAM.)

AS PHYSICIANS, THEY ARE COMMITTED TO GOD-LIKE INTERVENTION RATHER THAN SERVICE AND UNDERSTANDING. NEVER HAVING LEARNED TO BE SCHOLARS, THEY ARE UNPREPARED TO KEEP UP WITH AN EVER-CHANGING PROFESSION AND THEREFORE ARE AFRAID OF PEER JUDGEMENT OR OF ANYONE LOOKING OVER THEIR SHOULDERS. THEY ARE REACTIONARY RATHER THAN ADAPTABLE. THEY ARE WILLING TO SERVE HUMANITY IN THE AFFLUENT SUBURBS.

THESE ARE OUR OFFSPRING, FASHIONED IN OUR OWN IMAGE. WEARING PAROCHIAL BLINDERS, WE SEE MEDICAL EDUCATION AS THE THREE OR FOUR-YEAR SPAN BETWEEN COLLEGE AND THE M. D. DEGREE, SO WE PROCEED TO ADMIT AND ALMOST AUTOMATICALLY GRADUATE "QUALIFIED" APPLICANTS -- QUALIFIED TO SUCCEED IN OUR ISOLATED, LOCK-STEP CURRICULUM. AS THE ATTRITION RATE IN MEDICAL SCHOOL APPROACHES ZERO, OUR ADMISSIONS PROCEDURES BECOME THE METHOD OF DETERMINING WHO WILL PRACTICE MEDICINE, ABSOLVING US OF THE RESPONSIBILITY TO JUDGE OUR STUDENTS AND TO FAIL THEM IF THEY DON'T MEASURE UP.

SUGGESTIONS FOR CHANGING ALL OF THIS ARE NOT WANTING. WE ARE URGED TO COMPUTERIZE THE MOUNTAIN OF ADMISSIONS DATA IN ORDER TO IMPROVE ITS PREDICTIVE VALUE -- BUT WHAT KIND OF SUCCESS ARE WE TRYING TO PREDICT? WE ARE TOLD TO MAKE SPECIAL ALLOWANCE FOR MEMBERS OF MINORITY GROUPS, BUT IN OUR EAGERNESS TO ADMIT THE UNDER-REPRESENTED, WE HAVE REACHED THE INSANE POSITION OF INSISTING UPON ACADEMIC STANDARDS WHILE SETTING THEM ASIDE. SOME HAVE SUGGESTED THAT WE SET MINIMUM OBJECTIVE STANDARDS AND THEN HOLD A LOTTERY TO DETERMINE WHICH OF THE "QUALIFIED" APPLICANTS WILL BE ADMITTED; BUT THE ONLY TRUE EXPERIMENT WOULD BE TO CHOOSE BY LOT EQUALLY FROM AMONG BOTH THE "QUALIFIED" AND THE "UNQUALIFIED".

THEN THERE IS THE PROPOSAL FOR OPEN ADMISSIONS: LET EVERYONE IN AND THEN FLUNK MOST OF THEM OUT; BUT THE TRAVESTIES AND INEQUITIES OF THIS APPROACH HAVE BEEN ILLUSTRATED ABUNDANTLY IN OTHER PARTS OF THE WORLD. FURTHERMORE, IN THIS COUNTRY FLUNKING IS VIEWED AS A DISASTER, BECAUSE THE FLUNKEE HAS NOWHERE TO GO FROM THERE -- EXCEPT PERHAPS TO BECOME A DRUG-HOUSE FLUNKEY.

WE LIVE IN AN AGE OF CURRICULAR EXPERIMENTATION, BUT MOST OF THE CHANGES TRIED SO FAR SEEM TO ME ONLY TO AGGRAVATE THE PROBLEM. THERE IS NOTHING LESS FLEXIBLE THAN AN "INTEGRATED" CURRICULUM: THE COMMITTEE EFFORT REQUIRED TO SCHEDULE THE MANY SIMULTANEOUS INPUTS, THE ELIMINATION OF LABORATORIES, THE DEARTH OF REPETITION, THE COMPRESSION OR DISTILLATION OF SUBJECT-MATTER INTO A SHORTER TIME-SPAN, ALL INTENSIFY THE LOCK-STEP NATURE OF THE EXPERIENCE. I AM NOT SURPRISED THAT STUDENTS CONDITIONED BY ALL THIS ARE DISAPPOINTINGLY CONSERVATIVE IN THEIR APPROACH TO ELECTIVES. MOST MARVELOUS OF ALL, WE HAVE BEEN CONTENT TO EXPERIMENT WITHOUT DEFINING IN TESTABLE TERMS WHAT OUR EDUCATIONAL GOALS SHOULD BE.

WELL, THERE IS MY VIEW OF THE SITUATION. GIBBON IS QUOTED AS SAYING THAT CORSICA IS MUCH EASIER TO DEPLORE THAN TO DESCRIBE; I HAVE TRIED TO DO BOTH -- WITH WHAT SUCCESS I LEAVE YOU TO JUDGE.

IN THE FACE OF ALL THIS IRRATIONALITY, (I DO NOT BELIEVE THAT THE PRESENT APPROACH CAN BE MADE RATIONAL. THEREFORE, LET'S NOT WASTE TIME TRYING TO CUT AND PATCH. INSTEAD, LET'S REEXAMINE AND REDEFINE OUR GOALS -- AND TRY TO KEEP THEM FROM BECOMING MUTUALLY EXCLUSIVE. ONE GOAL MUST SURELY BE TO HAVE THE MEDICAL PROFESSION BROADLY REPRESENTATIVE OF OUR SOCIETY. FOR ANOTHER, WE SHOULD DEFINE OUR EDUCATIONAL OBJECTIVES IN TESTABLE TERMS.)

HOW DO WE WISH DOCTORS TO BEHAVE? SURELY NOT ALL ALIKE. ONLY BY ENCOURAGING PLURALISM CAN WE BEST UTILIZE DIFFERING HUMAN RESOURCES AND MEET MEDICAL NEEDS THAT WE CAN'T YET PREDICT. THEREFORE MEDICAL STUDENTS OUGHT TO BE SELECTED ON THE BASIS OF THEIR INDIVIDUAL POTENTIALITIES AND HELPED TO DEVELOP AS DIVERSELY AS THEY WILL. MEDICAL EDUCATION SHOULD PROMOTE ADAPTABILITY, SENSITIVITY TO HUMAN NUANCES AND AN AWARENESS OF THE WORLD WE LIVE IN, BUT AT THE SAME TIME STUDENTS MUST PREPARE TO ADOPT AS RIGOROUS AN APPROACH AS POSSIBLE TO SOLVING COMPLEX PROBLEMS REQUIRING IMMEDIATE SOLUTION -- ON THE BASIS OF INADEQUATE EVIDENCE. THEY NEED TO LEARN TO WORK EFFECTIVELY WITH OTHERS OF VARYING SKILLS -- WITH THE GOAL OF RENDERING SERVICE RATHER THAN RECEIVING PRAISE.

(DESIGNING A SYSTEM TO ACHIEVE THESE OBJECTIVES CAN NOT REALISTICALLY PROCEED UNTIL NEW METHODS HAVE BEEN DEVELOPED FOR EVALUATING THESE SKILLS AND QUALITIES. WE MUST DISCOVER HOW TO TEST COMPETENCE RATHER THAN JUST KNOWLEDGE. I SUSPECT THAT NO BRIEF, EPISODIC TYPE OF EXAMINATION WILL SERVE; SOME FORM OF SURVEILLANCE -- AS TERIFYING AS THAT SOUNDS -- WILL NEED TO BE DEVELOPED.)

ONCE IT IS POSSIBLE TO TEST FOR COMPETENCE, HOW CAN WE REDESIGN MEDICAL EDUCATION TO AVOID THE INSOLUBLE PARADOXES OF OUR PRESENT SELECTION PROCEDURES? HOW CAN WE RECONCILE DEMOCRACY WITH ACADEMIC STANDARDS?

LET US CONSIDER THE IMPLICATIONS OF ELIMINATING THE THRESHOLD BETWEEN COLLEGE AND MEDICAL SCHOOL, REPLACING IT WITH A FLEXIBLE INTERFACE ACROSS WHICH STUDENTS PASS WHEN PREPARED. STUDENTS, UPON ENTRANCE TO COLLEGE OR AT SOME LATER TIME, WOULD ENROLL TO LEARN HEALTH CARE, WOULD PROGRESS AT THEIR OWN SPEEDS AND WOULD ACCUMULATE THE PREREQUISITES FOR ADVANCED STUDY BY PASSING COURSES OR EXAMINATIONS. IF EXAMINATIONS TRULY TESTED COMPETENCE AT EACH ACADEMIC LEVEL, IT SHOULD NO LONGER BE NECESSARY TO FULFILL ANY PARTICULAR COURSE OR RESIDENCY REQUIREMENTS -- ONLY TO LEARN AND TO GROW COMPETENT. (EXAMINATIONS MIGHT THEN BE SEEN IN THEIR PROPER ROLE: NOT AS RETROSPECTIVE EVALUATIONS OF PERFORMANCE IN A PARTICULAR ISOLATED COURSE, BUT AS CERTIFYING ONE'S PREPAREDNESS FOR THE NEXT LEVEL OF GROWTH.) THEN ACADEMIA AND THE REAL WORLD WOULD BECOME ONE.

NOW YOU MAY ARGUE THAT I HAVE IGNORED THE PROBLEM OF AN OVER-ABUNDANCE OF APPLICANTS TO MEDICAL SCHOOL, BUT IF CREDIT CAN BE GAINED BY EXAMINATION INSTEAD OF ENROLLMENT IN MEDICAL SCHOOL, THEN STUDENTS MIGHT LEARN BASIC SCIENCES IN UNDERGRADUATE COLLEGES AND CLINICAL MEDICINE IN COMMUNITY HOSPITALS, TURNING TO MEDICAL SCHOOL BASIC SCIENCE DEPARTMENTS AND UNIVERSITY TEACHING HOSPITALS ONLY FOR THE MOST ADVANCED LEVELS OF LEARNING. THE DEVELOPMENT OF A CAREER LADDER, WITH OPPORTUNITIES FOR PRACTICE AT MANY LEVELS OF EDUCATION WOULD DIVERT THOSE APPLICANTS NOT REALLY READY FOR MEDICAL SCHOOL. THEREFORE THE HEALTH-CARE EDUCATION ENTERPRISE, SO CONSTRUED, PROBABLY COULD ACCEPT ALL THOSE REALISTICALLY INTERESTED IN ENTERING, AND THE EXPANDING DEMANDS FOR HEALTH CARE PROBABLY COULD USE THEIR SERVICES.

IN SUMMARY, I DO NOT THINK THAT ADMISSION TO MEDICAL SCHOOL CAN BE MADE RATIONAL UNDER THE PRESENT CIRCUMSTANCES. INSTEAD OF TRYING TO PATCH A FAILING SYSTEM WE SHOULD BE DESIGNING A NEW ONE, BASED UPON THE GOAL OF FLEXIBLY DEVELOPING EACH STUDENT'S POTENTIAL. BEFORE THIS CAN BE ACHIEVED, IT WILL BE NECESSARY TO DEVELOP MORE REALISTIC METHODS OF CERTIFYING COMPETENCE.

IN THE MEANTIME, WE HAVE A PROBLEM. AS THEY SAY, WHAT'S A MOTHER TO DO?

ATT. B.

3-3

or

4-4

or

4-3

or

3-4

by

Carleton B. Chapman, M. D.

Dartmouth Medical School

4 February 1972

The efforts of those faculties and those deans that have begun to experiment with three-year medical school curriculums are now beginning to be "viewed with alarm;" which should surprise no one. "The three-year medical school has become a popular idea," says Dr. August G. Swanson (1); as indeed it has. One might add that, for many years it hasn't really been an unpopular idea; it has merely been more or less dormant. "Are three years better than four?" asks Hans Stetten, somewhat rhetorically (2). He goes on to attack everything except the status quo and says, among other things, that the shortened M.D. programs, on the one hand, and the new physicians' assistant curriculums, on the other, promise to become difficult to distinguish. The burden of his argument is that three years is too short a time to provide quality training to the M.D. level but, quite illogically, goes on to say that "The number of years which intervene between baccalaureate and doctoral degree is ... not important provided the product, the physician, is a continuing scholar in medicine."

The stimuli for such comments - Dr. Swanson's judicious editorial and Dr. Stetten's article in Science - were probably the Carnegie Commission's report of two years ago (3), and the Comprehensive Health Manpower Training Act of 1971 (4).

The Carnegie Commission favored "... a program calling for three years (instead of four) after the B.A. to obtain the M.D. .... and a three-year residency (instead of the typical four years of internship and residency)." The Commission also noted that if all medical schools



went to three-year M.D. programs, the number of places for first-year students would be increased by an estimated thirty-one per cent within a few years. To drive home its point, the Commission said that moving to a three-year M.D. program would increase the size of each class by a third " ... without increasing the total number of students enrolled at any one moment of time and without requiring additional physical facilities." The Commission acknowledged that more faculty would be required but added that "... substantial savings would nevertheless be possible."

Then came the Comprehensive Health Manpower Training Act with its offer of a special bonus for each three-year M.D. graduate. No doubt, the opinions offered by the Carnegie Commission were in considerable measure responsible for the inclusion by Congress of the three-year bonus. Whether it is a wise provision or not, and what its actual effect will be, I doubt that anyone can as yet be certain.

But I should like to support the main thrust of the Carnegie Commission's recommendation and to do so with reasoning that differs from theirs. In the first place, I think their arithmetic is bad: (I do not see how we can increase the annual output of physicians by moving from a four-year to a three-year curriculum. The only way to increase output significantly is to increase the size of the first-year class.) There would, as Blumberg shows (5), be an increase in output for a single year if all schools went over to the three-year curriculum simultaneously. But ~~unless the number of first-year places be increased simultaneously,~~ <sup>would be</sup> that is all. *unless, of course, the number of <sup>chronologic</sup> first year places were increased along with the shortening of the requirements for the MD degree.*

I might add, parenthetically, that simultaneous expansion of the first-year class, and installation of a three-year M.D. curriculum - expansion at both ends at the same time - places great strain on any medical school and ought to be viewed very cautiously. (But the main justification for the three-year M.D. program cannot be that it will increase our annual output of physicians.) It will, of course, increase the number of physician man-years available to the consumer of physician services, but this is a very long-term effect.

And what about costs? (Will the three-year M.D. program actually be less costly in dollars than the four-year program? In disagreement with the Carnegie Commission, I answer in the negative.) The cost to the student will probably wind up about the same; the three years will cost him the same, or only slightly less, than four years under the current system. The cost to the institutions, excluding any consideration of expanding physical facilities, will not be less and could, for a few years, even be more.

#### Why Not Three years?

It's my view, in short, that (the Carnegie Commission may have used inadequate arguments for their conclusion and that the Congress may have false hopes with regard to the ultimate effect of the Three-Year Bonus.)

Be this as it may, I should like to turn the query around and ask the traditionalists: why not a three-year program? What is so magic about the number four? And I remind my status quo colleagues of the simple fact that, since the thirties, the fourth year of the M.D. curriculum has

become increasingly redundant. More and more we have either allowed students to do interne's work in that year; or, in the case of those with little ambition, we have simply let them mark time, in idleness or ineffective simulated activity, until that great moment comes when the four years has elapsed and the M.D. degree can be awarded. Yet the obvious suggestion (if the fourth year cannot be made meaningful for all or most students it should be made optional - brings forth a chorus of alarmed comments, dire predictions about degradation of quality (undefined), and vague comments about student maturity (also undefined). In my own experience, I have heard the same learned and conscientious men deplore the ineffectiveness of the fourth year, then turn vigorously to its defense when it is threatened.)

It ought, by now, to be clear to most that in the midst of all this argument between the traditionalists and the progressives there is a uniform avoidance of clear definition of what each is talking about. What is a three-year curriculum? Is it 32 months or is it 39? And what, for that matter, is a four-year curriculum? Is it 36 months or 44? There are, incidentally, nominal three-year programs that inexplicably require 39 months of instruction; and there are four-year programs that require 36 months. Also, for whom are the three-year programs designed? for all or most students? Or for the specially gifted? Or merely as an option alongside the four-year program? It seems to me that, to accomplish anything really useful, the three-year curriculum ought to be completed within three calendar years and should involve no more than 33 months of instruction. And it ought to be an option open to, and suitable for, most students.

Whether this is acceptable or not, it may be as well, in a situation marked by this degree of confusion, to seek common points of agreement, if such there be.

*It has become a learning experience that differs significantly from the traditional one and is not merely a mere squeezing*

- 5 -

Whether <sup>or not</sup> this - which is one concept of Outward - is generally acceptable, everyone agrees that quality must be maintained and most agree

5.

~~For one thing, everyone argues for quality, a word that means all sorts of things; for another, all seem to agree that the learning experience should be tailored, within unspecified limits, to fit the needs of the individual student. We have been paying lip service to these vague entities for a very long time.~~

#### The Era of Accretion

In fact, when the popular view was that medical curriculum should be lengthened, the points of agreement and the justifications, were similar to those of the present time. The arguments for the addition of a fifth year to the M.D. program had to do with quality and with the needs of the individual. Lambert held in 1916 that the addition would remove all clinical work from the first two years, would unclutter the curriculum, and provide abundant time for collateral reading (6). These arguments prevailed but there were those who disagreed. James Ewing (1915), for example, argued against "... the sudden development of a scheme to add a fifth and wholly clinical year to the curriculum without any consideration of the needs of medical education as a whole" (7). His comments went unheeded. Not only was a fifth year - the internship - added; premedical requirements became longer and increasingly specific. Not even the most respected elder statesmen could influence the trend. W. H. Welch (1917) thought it "... a very horrible thing to attempt to indicate the number of hours ... to be devoted to a subject ...." (8). And Charles Emerson, a bit later (1923) deplored the fact that we "... hold all we have as we add still more courses ...; to reach a minimum

in each subject takes so much time that there is no chance to reach a maximum in any" ( 9). And no less a person than President Lowell of Harvard attacked the rigid requirements set up in 1913 by the American Medical Association and the Association of American Medical Colleges. "You are," he said, " requiring not a result but a process; you are ascertaining ... whether [a student] has gone through a regime of training which may in ordinary cases [be suitable] ... but which is sometimes not necessary ... and often inadequate" (10). And shortly afterward, Charles McIntyre urged that American Academics define the knowledge to be acquired before beginning the study of medicine; and determine the knowledge needed to practice medicine. "Upon these minima," he wrote, " let each school build its course" (11).

Then there was Dean Edsall of Harvard attacking the whole sweep of education for medicine. The requirements were, he held, "... too schematic and too rigid as to doing certain precise things in ... certain sequence, in definite courses of a definite character and for a definite length of time" (12).

#### Flexner, Ten Years After

All to no avail. As Painter pointed out, Abraham Flexner had very properly set in motion "... corrective machinery which has been ... drastic in its effect ... [and is] difficult to keep under control" (13).

What about Flexner himself? He rendered his famous Report in 1910

*for nearly half a century after that. It wasn't many years*  
and lived to ~~observe its results for nearly many years. These results~~  
*before the results according from his report*  
were not altogether to his liking. Nearly fifteen years after the report  
was published he had this to say:

"The graded four-year curriculum has itself now become more of a hindrance than a help .... It is not by any means a finality. Its uniformity is nothing short of an absurdity. What sound reason can be given for requiring the able and the less able, the industrious and the less industrious, to complete practically the same course of instruction in the same period of time? ... With very few exceptions, all American medical students spend the same length of time in the medical school and pursue the same courses to the same end. More than this, the medical schools, though in name university departments, charge themselves with a degree of responsibility for their students which is utterly out of place anywhere but in an elementary school. These two characteristics, namely, the uniform graded four-year course and the paternal, not to say maternal, responsibility which the university medical school in America feels for its students, has compelled the best ... schools to reduce their enrollment to such a point that their opportunities are open to relatively few and their per capita costs are ... prohibitively high" (14).

This from none other than the man who, working in cooperation with the Council on Medical Education and with support from the Carnegie Foundation, set American medical education on a new and greatly refined course. But he obviously had not foreseen the stultifying effects of the various forces for rigidity: legislatures specifying course hours and content; the natural conservatism of the medical profession and its virtual immunity from non-medical criticism. Flexner had, fifteen years earlier, attacked the overproduction of doctors and called for limiting numbers and raising quality (15). He had not specifically abandoned those goals in 1924 but he very clearly had the gravest misgivings about the directions in which medical education had moved, to some extent because of his Report. He did not, in 1924, call for a reduction in the time required for the acquisition of the M.D. degree: his plea was for a rationalization and a loosening up of the whole system. And one inference seems <sup>inescapably from his comments:</sup> ~~very clear~~ the very rigidity which had grown up, ostensibly in the interests of improving quality, <sup>had begun to</sup> ~~now impaired~~ it.

#### The Arguments Fifty Years later

And now, nearly fifty years after Flexner's critique of the effects of his report, <sup>than an hour of us who</sup> ~~one~~ finds his arguments - and those of President Lowell, Dean Edsall and many others - still quite compelling. One wonders, in fact, how medical education, with such respected and influential critics at hand, managed to sink so totally into somnolence between the two major wars of this century.

The argument today is very much in keeping with the line taken by Flexner in 1924: the argument in favor of a three-year M.D. program for some, if not all, students resolves itself into a renewed plea for combatting medical educational rigidity.

~~and for recognition without a degree~~  
~~and for the fact that we train our students for many different roles in the health area.~~  
 I believe the move is overdue partly because many American students are better prepared when they come to us than was the case fifty, or even twenty-five, years ago. I also repeat one of Ewing's points, made in 1915: the addition of the internship (and residency years) was never considered in relation to the design, sequence, and content of the pre-M.D. curriculum. The strong suggestion is that some more technical and practical portions of the M.D. curriculum, originally added when the young physician entered practice immediately on receiving his degree, can safely, and to advantage, be deferred to the post-M.D. period.)

Basically, ~~then~~ the plea is for a somewhat rearranged curriculum, some change in content, and much more leeway with regard to time requirements. Some students, ~~as Dr. Swanson points out in his recent editorial,~~ can complete the requirements for the M.D. degree in three years; some need four; and some need five. We should design a system that will accommodate them all. The proportion that will follow each of the sequences will undoubtedly vary from school to school. But ~~it is my conviction~~ that in the fullness of time, most will follow the three-year sequence.

In fact, I think it likely that most future physicians will follow a 3-3-3 sequence: three years of college, three of medical school; and three of post-M.D. training. I also believe that if properly designed,



such a 3-3-3 sequence can easily be the equivalent in effective learning and training of most present-day 4-4-4 sequences.)

Probably the greatest danger facing us now is not that the three-year M.D. curriculum will become standard; more threatening is the prospect that it will become the rigid rule and that we will soon be back in the same old dilemma. This, I believe, can be avoided but, medical education and the profession being what they are, it will take some doing.)

And finally, what about quality? In this regard none of the standard rules of debate apply: quality to the basic scientist means proficiency in his discipline; to the clinician it means adequate performance (itself definable at many different levels) at the bedside; to the sophist it means skillful sophistry; to the pedant it means addiction to pedantry: to each his very own definition. One can try to create a more general definition focussing, for present purposes, on the point in time when the student receives his M.D. degree. A quality product is one who understands and can apply (at the very least) the most relevant aspects of the basic biomedical sciences; who has acquired general orientation in clinical medicine and psychiatry; and who pays much more than lip service to biomedical scholarship. No doubt one could define quality many other ways; but however this may be, (I have no prescription for producing quality, as I define it, in all, or even in most, M.D. candidates. As a profession we have steadfastly declined to define quality in any but a few inadequate

contexts. But however one may define quality, it can in no sense be guaranteed by worship of the magic number four; whether the reference is to training at the baccalaureate level, or in medical school.)

But quality and individual student preference are both important and there is no reason to believe that a properly planned 3-year M.D. program will impair either. In any event, there are something like twenty-six schools (16) experimenting with three-year programs. Many are very prestigious schools; and most offer the three-year route as an option. At Dartmouth, our intent is to ascertain whether or not the three-year M.D. program may not be made to fit the needs of most students; but we have no intention of permitting it to become the required sequence, *whatever they do after they receive the M.D. degree.*

In summary, it is my conviction that the Carnegie Commission made the right recommendation for the wrong reasons. And (I can find little merit in the laments of those who adhere so anxiously to the four-year sequence merely because four years is longer than three years. I make no plea for other schools to join the twenty-six of us who are testing three-year curriculums. But I do urge them to take into account the implications of their own experience and to consider <sup>seriously</sup> what so many able, and often sympathetic critics of medical education have been telling us for <sup>so</sup> many years.)

The three-year M.D. curriculum will not quietly vanish. On the contrary, it may one day become the national norm.

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