aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

Washington Hilton Hotel
Washington, D.C.

September 14, 1977

5:00 p.m.	Business Meeting	*Jackson Room*
7:30 p.m.	Cocktails	*Kalorama Room*
8:30 p.m.	Dinner	*Jackson Room*

Guest: *Gilbert S. Omen, M.D., Ph.D., Assistant Director for Social & Economic Services, Office of Science & Technology Policy*

September 15, 1977

8:30 a.m.	Business Meeting *(Coffee and Danish)*	*Jackson Room*
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon and Executive Council Business Meeting	*Conservatory Room*
4:00 p.m.	Adjourn	

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 14-15, 1977

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS:

1. Approval of Minutes of CAS Administrative Board Meeting of June 22-23, 1977 1

2. New Membership Applications:

- *Society for Surgery of the Alimentary Tract*..... 9
- *Society of Teachers of Emergency Medicine*..... 11

3. Executive Council Action Items:

- Endorsement of LCME Accreditation Decisions
- Removal of Schools from Probationary Accreditation
- Election of Provisional Institutional Member
- Election of CAS Member
- Election of COTH Member
- Election of Distinguished Service Members
- Election of Emeritus Members
- Election of Individual Members
- Approval of Subscribers
- Flexner and Borden Award Nominations
- Individual Membership Dues Increase
- Amendment of the CAS Rules and Regulations
- Amendment of the GME Rules and Regulations
- FY 1978 CCME Budget
- Statement on Withholding of Services by Physicians
- Establishment of a Cabinet Level Department of Health
- Recognition of LCME by U.S. Commissioner of Education
- Summary of Proposed AAMC Testimony on NAS Report, "Health Care for American Veterans"

III. DISCUSSION ITEMS:

1. Status Report: Legislative Activities

2. Annual Meeting Program Plans 14

3. Executive Council Discussion Item:

- Task Force on Minority Student Opportunities in Medicine Interim Report

IV. INFORMATION ITEMS:

1. CAS Services Program Status Report

2. Ad Hoc Group on Biomedical Research

3. Report of the CAS Nominating Committee

4. Executive Council Information Items:

   - Shared Schedule Residency Training Positions
   - LCME Actions

V. NEW BUSINESS

(Note: The Attachments to the Minutes are included at the end of the Agenda)

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 22-23, 1977

Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members

A. Jay Bollet,
Chairman (Presiding)
Robert M. Berne
F. Marian Bishop
Eugene Braunwald*
Carmine D. Clemente
Daniel X. Freedman*
Rolla B. Hill
Roy C. Swan
Samuel O. Thier*

Staff

John A.D. Cooper*
James Erdmann
Paul Jolly*
Thomas Kennedy*
Mary Littlemeyer
Thomas Morgan
Mignon Sample
John Sherman
August Swanson

ABSENT: Thomas K. Oliver, Jr.
Leslie T. Webster

Guest: Thomas E. Malone, Ph.D.**

The CAS Administrative Board Business Meeting convened on June 22nd at 5:15 p.m. and adjourned at 7:30 p.m. A social hour was followed by dinner at 8:30 p.m. Dr. Thomas Malone, Associate Director of Extramural Research and Training at the National Institutes of Health, joined the Board for an informal discussion of current NIH concerns.

The meeting reconvened at 8:30 a.m. on June 23rd. Following the usual custom, the CAS Administrative Board joined the other AAMC Boards for a luncheon meeting at 1:00 p.m.

*For part of the meeting
**Associate Director, Extramural Research and Training, National Institutes of Health

I. Adoption of Minutes

The Minutes of the CAS Administrative Board Meeting of March 30-31, 1977 were adopted with one amendment. Dr. Bishop noted that the last sentence in Action Item B (CMSS Liaison), "and subsequent meetings on an individual basis," should be deleted because the CMSS had been issued a standing invitation to attend the CAS Board Meetings.

II. Action Items

A. Amendment to the Rules and Regulations of the Council of Academic Societies

Several changes were proposed in the CAS Rules and Regulations to modify the present system for nominating and electing CAS Administrative Board Members. These included eliminating the dual slate for election of CAS officers, providing for appointment of the CAS Nominating Committee by the Administrative Board rather than by election at the Annual Meeting, and replacing the Chairman of the CAS with the Immediate Past-Chairman as Chairman of the CAS Nominating Committee.

Dr. Braunwald commented that the single slate system would only serve to make the CAS self-perpetuating, because the Administrative Board would select the Nominating Committee which would then select the Administrative Board. He added that the dual slate gives the members a sense of participation in the governance of CAS. It was the general consensus of the Board that the present election of the Nominating Committee is awkward, but that the election of officers should be left as is.

ACTION: On motion, seconded, and carried, the CAS Administrative Board revised Paragraph 1, Section V. Committees, of the CAS Rules and Regulations to amend the selection of the CAS Nominating Committee as follows.

Section V. Committees

1. The Nominating Committee shall be comprised of seven members of the Council. The Chairman of the Administrative Board shall be the seventh member (ex officio) and shall vote in the case of a tie. The Nominating Committee will consist of six individuals (3 basic science and 3 clinical science) who shall be appointed by the CAS Administrative Board from among the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board.

B. Endorsement of LCME Accreditation Decisions

Dr. Morgan and several of the Board members commented on the decision requiring Howard University to produce progress reports after being granted a 7-year accreditation status. Although the decision had already been made, it was suggested that Board members can comment on this or any other of the LCME decisions.

Dr. Swanson explained that the rationale behind extending the maximum accreditation to ten years is to better coordinate the accreditation cycles of both the university and the medical school, and also because of the increasing burden of the number of medical schools and the complexity of the site visits. There was also a discussion of provisional accreditation and the rationale behind that type of decision.

ACTION: The CAS Administrative Board voted unanimously to ratify the LCME accreditation decisions.

C. Election of Provisional Institutional Members

ACTION: The CAS Administrative Board recommended election of these schools subject to approval by the Council of Deans and the Assembly.

D. Election of COTH Members

ACTION: The CAS Administrative Board recommended election of these COTH members subject to approval by the Council of Teaching Hospitals and the Assembly.

E. Approval of Subscribers

Dr. Swanson explained that this is a new category of membership designed to provide an opportunity for branch campuses to receive AAMC publications, etc.

ACTION: The CAS Administrative Board recommended approval of the schools listed for subscriber status.

F. AAMC Position on the Withholding of Professional Services by Physicians

Initiated by Dr. Krevans, the suggestion was made that the AAMC consider the appointment of a small working group to examine the ethical issues involved in the withholding of services by groups of physicians in order to bring pressure to bear on the solution of perceived problems. Dr. Clemente

provided some background on the situation at UCLA and in California. Considering that this is an ethical question, Dr. Thier felt that the AAMC does have an obligation as molders of professionals to take a position on the issue. It was the consensus that the AAMC cannot condone striking; however, it was felt that this issue could compromise the Association and might be viewed as an institutional response to housestaff unionization.

ACTION: The CAS Administrative Board approved the recommendation to appoint a small working group to produce a policy statement on the withholding of professional services by physicians.

G. Specialty Recognition of Emergency Medicine

Dr. Swanson gave an historical background of the action by the Liaison Committee on Specialty Boards to recommend the establishment of a specialty board in emergency medicine. A meeting of a study group appointed to recommend an AAMC position had taken place on Tuesday. Dr. Samuel Thier, as a member of that group which also included Drs. William Luginbuhl, Charles Womer and George Zuidema, reported on the group's deliberations.

He noted that emergency medicine has expanded enormously and that, in the face of this reality, it is essential to assure quality of service, maintain flexibility in training programs, and minimize the possible negative impact on medical schools and teaching hospitals. Considering several options, including the establishment of a primary board, the group recommended that the AAMC support the establishment of a conjoint board with mandatory representation from the primary boards in family practice, internal medicine, pediatrics and surgery. There was a strong consensus of the significant advantage of upgrading emergency medicine by formulating a conjoint board. This solution would provide for the maintenance of quality and flexibility in training programs, and could be accomodated within existing hospital and medical school structures.

(The discussion of the issue was continued on Thursday, June 24th, when the report of the study group was distributed, Attachment I.)

Dr. Braunwald commented that this could establish a dangerous precedent, and felt that the AAMC should oppose the establishment of any type of board. Dr. Clemente expressed the view that the establishment of a conjoint board was a very logical solution considering the arguments put forth by Dr. Thier and members of the study group.

ACTION: On motion, seconded, and carried, the CAS Administrative Board recommended that the AAMC oppose establishment of any type of emergency medicine board; however, the Executive Council should instruct the representatives to the ABMS that should this position fail, the next alternative is to support the establishment of a conjoint board; and the third alternative would be establishment of a representative board. This motion was approved by five Board members, opposed by one, and one member abstained.

H. Draft Response to the GAO Report

The report by the General Accounting Office on "Problems in Training and Appropriate Mix of Physician Specialists" has been received by the Association for comment. The basic recommendation of the report was that the CCME be contracted by the Secretary, HEW to develop and implement a system which would assure the training of the optimal number and mix of specialists.

Dr. Cooper reported on the discussions at the last meeting of the CCME and on the letter which has been drafted by the AAMC. In essence, while there was acceptance of the concept that CCME should attempt to better relate residency training to national needs, several disadvantages of the CCME undertaking this effort were discussed, including the difficulty of accomplishing this without regulatory mechanisms and the reality that acceptance of funding from DHEW would convert the CCME into a quasi-government organization. The abolishment of GMENAC was recommended if the CCME were to accept this challenge. Dr. Swanson commented that an effort is being made to develop a modus operandi between the public and private sector in order to have appropriate deliberation by the private sector regarding manpower needs.

ACTION: The CAS Administrative Board concurred with the recommendation that the Executive Council review the position of the AAMC and make the recommendations as outlined in the Executive Council Agenda.

III. Discussion Items

1. Implementation Steps for CAS Services Program

Dr. Swanson presented a brief summary of the steps taken to develop the program and the rationale behind this action. It had been the consensus of the Executive Committee that this program would provide a unique opportunity to resolve some of the problems which are developing regarding interactions with constituent societies as evidenced by the rapid escalation of hiring lobbyists.

There were many concerns raised by the Board Members, particularly the feeling as expressed by Dr. Hill that there had not been a mandate from the Executive Council to actually proceed with the program, but rather an expression of interest in exploring possibilities and carefully considering a number of cautions that had been raised by the CAS Administrative Board in previous discussions. The motivation behind the APM's request was questioned by Dr. Clemente, and several other Board Members agreed that this step might well be perceived as another example of the strong influence that internal medicine is believed by many to have on the AAMC. Another concern raised was that this program might create divisiveness among the societies if it appeared to be targeted at the special interests of one particular group, or appeared to be giving an advantage to that group by virtue of the close proximity and access to Association staff.

In responding to these concerns, Dr. Cooper indicated that the APM at the time was waiting for a decision and the financial considerations had to be reviewed by the Executive Committee. (The Minutes of the Executive Committee on this issue are shown in Attachment II.) Dr. Bollet expressed the feeling that the concept as it had been developed by the staff was to use the APM proposal as a prototype in an experimental project to establish a mechanism for promoting more faculty participation in the AAMC. It was pointed out that the access and information exchange in the program was a distinct advantage for the entire CAS because it can strengthen the relationship between the CAS and its constituents. Regarding the concern about lobbying activities, Drs. Sherman and Swanson emphasized the statement in the proposal that the staff associate would not contact members of the Congressional staff without prior consultation with AAMC staff, and that any AAMC lobbying activities would have to be limited to generic issues rather than categorical interests.

Dr. Thier proposed a tentative solution of recommending to the Executive Council that the AAMC proceed with the program as developed with the APM; however, the other half of the funds already committed should be allocated to extending the program to one or two basic science societies who would pay only the direct costs for the services.

The general consensus of the Board was that the main problem is one of image, specifically that the AAMC is perceived as an internal medicine group; and that if the program is to be implemented, the faster these services can be extended to involve other societies, the sooner that image can be dispelled. Dr. Freedman commented that if this experiment produces results that the other societies can relate to, it will be a successful ex-

perience that would provide benefits for everyone. Some questions were raised regarding the addition of a basic science society to the program, including how the additional society would be selected, whether this society would have the same commitment to the program and if they would be compatible to the APM, and what the next step will be when the experimental phase is completed as regards funding for the program.

ACTION: After a thorough discussion of the many concerns raised by the Board Members, it was the consensus of the CAS Administrative Board that if this experiment is to be successful, and in order to dispel the perception that the AAMC is an internal medicine group, the services program should proceed for the experimental phase as directed; however, it should be extended to other societies (particularly a basic science chairmen society) as rapidly as possible.

2. Resolution Concerning the Death of Thomas Kinney

ACTION: On motion, seconded, and carried, the CAS Administrative Board concurred that a resolution be forwarded expressing the AAMC's regret on the death of Thomas Kinney, who played a major role in the formation of the CAS and the activities of the AAMC.

3. Status Reports

A report on the Liaison Committee on Graduate Medical Education prepared by Dr. Swanson for the April COD meeting was distributed to the Board Members (Attachment III).

Dr. Morgan gave a brief summary on the legislative activities in Appropriations, Recombinant DNA, and the Clinical Laboratory Improvement Act.

4. CAS Interim Meeting

A discussion of the CAS Interim Meeting, which was held on Wednesday, June 22nd at AAMC Headquarters, indicated that the meeting was a success; 43 societies being represented at that meeting. Several options for future meetings were discussed and ideas on continuing these types of meetings were expressed for the staff to further develop.

5. Annual Meeting Program

The tentative agenda for the CAS/COD/COTH Joint Program was presented and suggestions were solicited for program participants.

6. CAS Brief Questionnaire

Mary Littlemeyer reported on the response to a questionnaire which had been sent to the societies regarding their interest in receiving bulk copies of the CAS Brief for distribution to their membership. (Attachment IV)

MS/jm
9/77

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: The Society for Surgery of the Alimentary Tract, Inc.

MAILING ADDRESS:
Larry C. Carey, M.D., Secretary
410 West 10th Avenue
Columbus, OH 43210

PURPOSE:

The objectives of the Society shall be to stimulate, foster and provide surgical leadership in the art and science of patient care, teach and research the diseases and functions of the alimentary tract, provide a forum for the presentation of such knowledge, and encourage training opportunities, funding, and scientific publications supporting the foregoing activities.

MEMBERSHIP CRITERIA:
To qualify for membership, a candidate must have (1) a degree from a medical school acceptable to the Trustees, (2) a license to practice medicine in his state, province, or country and (3) a demonstrable interest in diseaaes of the alimentary tract. In addition, the candidates customarily have (1) evidence of original research and published reports, (2) Fellowship in the American College of Surgeons, and (3) certificati on by an appropriat board.

NUMBER OF MEMBERS:

NUMBER OF FACULTY MEMBERS:
Not applicable

DATE ORGANIZED:
1960

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Included in front portion of Membership Directory enclosed — 1. Constitution & Bylaws

See Enclosure — 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

X YES _____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

_____

3. If request for exemption has been made, what is its current status?

X a. Approved by IRS

___b. Denied by IRS

___c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Current records do not have copy of letter. Identification number is 36-6147052, granted August 9, 1966

Adam C Rolnick

(Completed by - please sign)

1-7-77

(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Ms. Mignon Sample

NAME OF SOCIETY: Society of Teachers of Emergency Medicine

MAILING ADDRESS: 3900 Capital City Boulevard, Lansing, Michigan 48906

PURPOSE: The Society of Teachers of Emergency Medicine (hereafter called "the Society") is organized and operated exclusively for educational purposes, and in particular, to pursue the following objectives:

(a) Educating teachers of emergency medicine and encouraging its development as an academic discipline;

(b) Applying sound educational principles for the improvement of the quality of teaching in the field of emergency medicine;

(c) Promoting research in educational methods and clinical procedures which will improve the teaching of emergency medicine in universities and hospitals;

(d) Providing a forum for the interchange of experience and ideas among educators and other interested persons.

This organization is not organized for profit, and no part of any net earnings hereof shall inure to the benefit of any member, director, officer, or private individual (except that reasonable compensation may be paid for services rendered to or for the organization).

MEMBERSHIP CRITERIA:

Section 1. Members

Membership shall consist of those individuals who contribute, both monetarily and/or professionally to the Society as defined by the above purposes and objectives.

The Society shall be comprised of four classification of members:

(a) Active Members. Any physician who is actively involved in teaching physicians or medical students emergency medicine shall be eligible for active membership.

(b) Associate Members. Any non-physician actively involved in the teaching or organization of teaching physicians emergency medicine shall be eligible for associate membership. Such members would need sponsorship by an active member with the same benefits.

(CONTINUED NEXT PAGE)

(c) Honorary Members. An honorary membership may be conferred by the Executive Committee upon any non-member or member who has made an exceptional contribution to education in emergency medicine.

(d) Emeritus Members. Any Active Member who attains retirement age and requests a change in the status of his membership may be granted an emeritus membership, subject to such standards and requirements as may from time to time be established by the Bylaws.

Each application for membership shall be subject to initial approval by the Membership Committee.

Associate, Honorary, and Emeritus Members shall have the privilege of the floor at all meetings, the right to vote, and the right to hold elective office.

NUMBER OF MEMBERS: 75

NUMBER OF FACULTY MEMBERS: 60 (approximately)

DATE ORGANIZED: May 23, 1975 - organizational meeting
January 13, 1976 - articles of incorporation filed

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

May 14, 1976 1. Constitution & Bylaws

Program May 19, 1977
Minutes May 14, 1976 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

____X____ YES _____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501(c)(3)

3. If request for exemption has been made, what is its current status?

___a. Approved by IRS

___b. Denied by IRS

_X_c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Charles B. Maclean Ph.D.
(Completed by - please sign)

April 5, 1977
(Date)

AAMC ANNUAL MEETING
November 5-10, 1977
Washington Hilton Hotel

COUNCIL OF ACADEMIC SOCIETIES MEETINGS

Saturday, November 5

Individual Society Meetings

Sunday, November 6

Individual Society Meetings

5:00 p.m.	CAS ADMINISTRATIVE BOARD - Informal Meeting (Briefing/CAS Business Meeting Agenda)	CAS Suite

Monday, November 7

9:00 a.m.	Plenary Session	Ballroom
1:30 p.m.	CAS BUSINESS MEETING	Lincoln E&W
6:30 p.m.	CAS ADMINISTRATIVE BOARD RECEPTION (Welcome to new Board Members)	CAS Suite

Tuesday, November 8

7:30 a.m.	CAS PRESIDENTS BREAKFAST (Societies meeting in conjunction with AAMC - list shown on page 18)	Cabinet Room
9:00 a.m.	Plenary Session/Assembly	Ballroom
1:30 p.m.	COD/CAS/COTH JOINT PROGRAM "Challenges in Graduate Medical Education"	Ballroom Center

Wednesday, November 9

9:00 a.m.	COD/CAS/COTH JOINT PROGRAM "Challenges in Graduate Medical Education"	Ballroom Center

Thursday, November 10

Individual Society Meetings

COUNCIL OF ACADEMIC SOCIETIES

MONDAY, NOVEMBER 7, 1977
Lincoln East & West

BUSINESS MEETING

Chairman: A. Jay Bollet, M.D.

1:30 p.m.		Call to Order
	I.	Consideration of Minutes
	II.	Chairman's Report President's Report Director's Report
	III.	New Membership Applications
2:30 p.m.	IV.	Election of 1977-78 Administrative Board
2:50 p.m.	V.	Action and Discussion Items
4:50 p.m.	VI.	Announcement of Election Results
5:00 p.m.	VII.	"The Food and Drug Administration and the Academic Medical Centers" Donald Kennedy, Ph.D., Commissioner, Food and Drug Administration
6:00 p.m.		Adjourn

COUNCIL OF DEANS/COUNCIL OF ACADEMIC SOCIETIES/
COUNCIL OF TEACHING HOSPITALS

TUESDAY, NOVEMBER 8

Ballroom Center

CHALLENGES IN GRADUATE MEDICAL EDUCATION

SESSION I

TRANSITION BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

Moderator: Julius R. Krevans, M.D.

1:30 p.m. The Transition to Graduate Medical Education - A Student's Point of View
Thomas A. Rado, M.D., Ph.D.

The Readiness of New M.D. Graduates to Enter Their GME-1 Year
Barbara Korsch, M.D.

The Search for a Broad First Year
William Hamilton, M.D.

SESSION II

QUALITY OF GRADUATE MEDICAL EDUCATION

Moderator: A. Jay Bollet, M.D.

2:45 p.m. The Evaluation of Residents' Performance
John A. Benson, Jr., M.D.

Supervisory Relationships in Graduate Medical Education
William P. Homan, M.D.

The Program Director's Responsibility
Thomas K. Oliver, Jr., M.D.

4:00 p.m. Adjourn

COUNCIL OF DEANS/COUNCIL OF ACADEMIC SOCIETIES/
COUNCIL OF TEACHING HOSPITALS

WEDNESDAY, NOVEMBER 9

Ballroom Center

CHALLENGES IN GRADUATE MEDICAL EDUCATION

SESSION III

INFLUENCING SPECIALTY DISTRIBUTION THROUGH GRADUATE MEDICAL EDUCATION

Moderator: David D. Thompson, M.D.

9:00 a.m. The Coordinating Council on Medical Education Should Participate with the Federal Government to Regulate Opportunities for Specialty Training
John C. Beck, M.D.

The Private Sector Should Avoid Participating with the Federal Government
C. Rollins Hanlon, M.D.

SESSION IV

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION - THE McGAW MEDICAL CENTER OF NORTHWESTERN UNIVERSITY EXPERIENCE

Moderator: Robert L. Van Citters, M.D.

10:45 a.m. The Concept and its Development
James Eckenhoff, M.D.

How it Operates
Jacob Suker, M.D.

How it Affects the Program Director
Henry L. Nadler, M.D.

Its Impact on the Teaching Hospital
David L. Everhart

12:30 p.m. Adjourn

PRESIDENTS OF CAS MEMBER SOCIETIES MEETING IN CONJUNCTION WITH AAMC

Society of Academic Anesthesia Chairmen	Jerome H. Modell, M.D.
Association of Anatomy Chairmen	Alan Peters, Ph.D.
Association of Professors of Dermatology	Mark R. Everett, M.D.
Society of Teachers of Family Medicine	L. Robert Martin, M.D.
Association of Professors of Medicine	Grant W. Liddle, M.D.
Association of University Professors of Neurology	Lewis P. Rowland, M.D.
Society for Gynecologic Investigation	Paul MacDonald, M.D.
Association of Orthopaedic Chairmen	James W. Harkess, M.B, Ch.B.
Association of University Professors of Ophthalmology	Frederick T. Fraunfelder, M.D.
Society of University Otolaryngologists	Byron J. Bailey, M.D.
Association of Pathology Chairmen	Ellis Benson, M.D.
Association of Chairmen of Departments of Physiology	William F. Ganong, M.D.
American Association of Chairmen of Departments of Psychiatry	Donald Oken, M.D.
Association for Academic Psychiatry	Thomas G. Webster, M.D.
Society of University Urologists	Willard E. Goodwin, M.D.

THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

Genesis:

The Liaison Committee on Graduate Medical Education (LCGME) was established in 1973 under the sponsorship of five national organizations. These are:

Association of American Medical Colleges (AAMC)
American Board of Medical Specialties (ABMS)*
American Hospital Association (AHA)
American Medical Association (AMA)
Council of Medical Specialty Societies (CMSS)*

The representation on the LCGME from each sponsoring organization is:

AAMC - 4
ABMS - 4
AHA - 2
AMA - 2
CMSS - 2

Federal Government - 1
Public Member - 1
House Officer - 1 (Appointed by AMA Physician Resident Section)

The names and addresses of the current representatives are shown in Table 2.

The purpose of establishing the LCGME was to extend the scope of authority for the accreditation of graduate medical education to organizations whose constituents, although major participants in graduate medical education, had previously had little or no voice in setting standards and applying these standards to program accreditation. The establishment of the Liaison Committee gave tacit recognition to the essentiality of graduate medical education as the second phase of educating physicians and further indicated that all five sponsoring organizations recognized the need to develop policies and procedures consistent with the increasingly complex demands graduate medical education is making upon institutional and national resources.

The sponsoring organizations agreed that the LCGME would have the responsibility and authority to set the standards and accredit graduate medical education. They further agreed that "for the time being," the AMA would provide staff support for the newly-formed committee.

Simultaneously, the sponsoring organizations established the Coordinating Council on Medical Education (CCME), composed of three representatives from each of the five organizations (Figure 1). The CCME is responsible for broad policy development and for reviewing the activities of the LCGME, the Liaison Committee on Medical Education (LCME), and the Liaison Committee on Continuing Medical Education (LCCME) [Figure 2]. Major policy recommendations must be

*The member boards and societies of ABMS and CMSS are shown in Table 1.

referred to the CCME by the Liaison Committees and the CCME then refers these to the five sponsoring organizations. By agreement, AMA also staffs the CCME, "for the time being."

The System Which Was Operating:

From the outset, the LCGME faced a formidable task. The extent of this task cannot be appreciated without a brief review of the system for approval of graduate medical education programs which evolved under the auspices of the AMA, beginning shortly after World War II.

In the late 1940's, at the request of a number of specialty boards and specialty societies, the AMA undertook to establish and staff residency review committees (RRCs) for each specialty for which there was a certifying board. Not all began at once; indeed, pathology established an RRC under the AMA auspices only in 1972.

Each RRC is composed of members appointed by the certifying board and by the Board of Trustees of the AMA. Most, but not all, also have members appointed by a major specialty society (e.g. the American College of Physicians for internal medicine, the American College of Surgeons for surgery) [Table 3]. Staff support is provided to the RRCs by a "secretary" who is a full-time AMA staff person (usually an M.D.). A single secretary serves several RRCs.

The RRCs were empowered to develop the special requirements for programs in their specialty. These became official when approved by the sponsoring board, specialty society, and the AMA, and were published in the Directory of Graduate Medical Education ("the Green Book"). Since 1975, the LCGME has had the authority for final approval of special requirements.

Each RRC meets once or twice a year and reviews applications for approval of each program in its specialty which is up for review. The approval period is for three years. This periodicity requires that the 23 RRCs review a total of about 2,200 programs annually. The focus is on program review. Institutional considerations are completely secondary.

To develop the necessary data base upon which to make approval decisions, each RRC evolves its own application forms. Although the forms from one RRC request information similar to that from another, there is no consistency in the format of the data collection instruments.

Site visits are conducted either by AMA field staff or by specialist site visitors. The former are predominantly retired-physician employees of the AMA who travel from place to place to verify whether the data submitted are accurate and to submit their appraisal of each program for the record. Few of the field staff have had significant

experience as medical educators and, with 23 different specialties to cover, their expertise is severely strained. RRCs are increasingly utilizing specialist site visitors (SSVs) to carry out on-site inspections, particularly of programs that appear to be borderline in meeting standards. SSVs are generally selected from rosters prepared by the boards or specialty societies. It is estimated that 200 SSV site visits will be conducted this year.

The review procedure by each RRC consists, usually, of apportioning the applications and back-up information amongst the committee members for primary review in advance of the meeting. At the meeting, each application is discussed and the RRC makes a decision to approve, withhold or withdraw approval, or place a program on probation.

Prior to the LCGME's becoming officially functional in March of 1975 (when its by-laws were finally approved by the five sponsoring organizations), RRC action was final. There was no review beyond the RRCs and, although RRCs would reconsider their actions on request, there was no formal appeals procedure.

Defects, Deficiencies and Solutions:

As the LCGME began its organizational development in mid-1973, it began to review the individual actions by the RRCs on each program. Glaring deficiencies and inconsistencies were found. The first and most obvious was that programs were being continued in an approval status on probation for long periods. It was not uncommon to find programs which had been on probation almost from their inception. One of the first significant actions by the LCGME was to require that programs placed upon probation be reviewed in not less than two years, and that programs not clearing probationary status within four years be disapproved.

Because the LCGME was reviewing all the actions of all the RRCs, it also detected that in some cases a single institution might have the majority, or even all, of its programs on probation simultaneously. This led the LCGME to require that all RRCs be informed of the approval status of all the graduate programs being conducted by an institution when considering the application for a program in their specialty.

Many inconsistencies were found in the records of the RRCs. Most troublesome was the frequency with which the information in the official record of the program review was diametrically opposite to the RRCs action, without any documentation of why the RRC voted to approve or disapprove a program, when the record showed that the field staff or SSV had recommended the opposite. Since 1975, when the LCGME began reviewing RRC actions, this has been the most common reason for returning actions to the RRCs for reconsideration and explanation.

In addition, the LCGME invoked financial restrictions on the cost of RRC meetings. This was provoked by the finding that the cost per member per meeting for some RRCs was in excess of $1,000.

A document entitled "Structure and Functions of Residency Review Committees," designed to regularize the procedures of the RRCs, was developed and officially distributed to them for the first time in July of 1976.

Because, in the past, modifications in the special requirements were not considered from the standpoint of their impact upon the resources of the institutions or their effect upon the health care system, the LCGME has developed a policy that changes in special requirements must be accompanied by an analysis of the impact such changes will have upon resources in the institutions, justifying the expenditures of these resources by explaining how the changes in requirements will improve the quality of medical services to be provided by graduates of the programs.

Reactions:

Not surprisingly, having the LCGME granted the authority to begin holistically to review and modify the accreditation policies and procedures for 23 RRCs, which previously had been functioning essentially autonomously, has created anxiety, misunderstanding, and resentment. Unfortunately, much of the alleged conflict between the RRCs and the LCGME has resulted from the incredible inertia in the staff support supplied by the AMA. Information about LCGME actions fails to reach the RRCs in a timely fashion. While it had been expected that the secretaries to the RRCs (who attend all LCGME meetings) would inform them and assist in explaining the rationale of changes in policies and procedures to the RRCs, it is apparent that many times RRC members are not informed at all, or are misinformed.

Frustration with this seemingly immovable barrier to the effective functioning of both the LCGME and the RRCs has reached a high level. In January, 1977, the LCGME established a subcommittee on future staffing. The AAMC and the ABMS have officially recommended that an independent staff be developed. The CMSS and AHA are considering similar positions.

The Future:

The LCGME has revealed the need for having a broadly representative national body with the authority to accredit graduate medical education, and has demonstrated that such a body can improve accreditation without preempting the responsibilities of the specialists

who have the knowledge and experience necessary to evaluate the substantive quality of graduate medical education. It must continue and it must become more effective.

Several policy and procedural questions which should be studied and resolved are immediately apparent.

1) Should the membership of the RRCs be reconstituted?

The AAMC's Executive Council has recommended that, in lieu of having the AMA Board of Trustees appoint members to each RRC, the LCGME appoint members to each committee from a roster of individuals nominated by the LCGME sponsors. This would assist the development of a closer working relationship between the RRCs and the LCGME and would facilitate the progressive modification of RRC policies, vis-a-vis their special requirements, by eliminating the AMA's House of Delegates from the review process. RRC policy changes, after approval by the sponsoring board and specialty society, would become final when approved by the LCGME.

2) Can the review procedure be made more effective?

The accreditation review process needs thorough study and modification. A common format for the institutional data required by RRCs could be developed, and the provision of these data by institutions could be scheduled so as to serve the needs of each RRC without requiring redundant submissions by the institutions.

The possibility of doing away with the field staff visits and substituting organized teams of specialist site visitors to review all the graduate programs of an institution at the same time needs to be explored.

3) Is it necessary to review all programs every three years?

The rationale of requiring a review of every program every three years needs to be questioned. Lengthening the period between routine reviews to six years could substantially decrease the burden on staff and volunteer site visitors, and improve the evaluation, at more frequent intervals, of marginal programs.

4) Can the LCGME afford the costs of developing an independent staff?

The 1977 budget for LCGME provides for the expenditure of $1,446,042. This figure includes $269,074 in overhead charges by the AMA. Income will be derived as follows:

Charges to programs for review (@$300)	$660,000
AMA contribution of 50% of total expenses	723,018
Costs shared by sponsoring organizations ($3,939 per seat on LCGME)	63,024
TOTAL	$1,446,042

Modifications in the review procedures and staff activity may (or may not) effect a reduction in costs. Increasing charges to programs for review to $600 would generate $1,320,000 if the current frequency is continued. An increase in maximum approval period from the present three years would reduce the annual income.

Conclusion:

The process of establishing the hegemony of the LCGME over graduate medical education has necessarily been evolutionary. Through this process, obvious weaknesses in the way accreditation was being accomplished were identified and steps were taken to eliminate or correct them. Exertion of authority by the LCGME has been resented by the RRCs and misunderstandings have been exaggerated by a staff resistant to change and resentful of the added burden imposed by the LCGME.

It seems inescapable that future improvements in standard setting for graduate medical education and its accreditation will require an effective staff which is independent of any of the sponsoring organizations of the LCGME. Such a staff must be responsive to innovative modifications developed by the RRCs and the LCGME, and not wedded to perpetuating antiquated policies and procedures.

Changing the staff alone will not be enough. Conventional attitudes about the independence of each specialty's graduate programs from other specialties and from an institutional framework must change amongst members of certifying boards, specialty societies and faculties.

Despite adversity, the LCGME has shown that nineteen people, coming with diverse viewpoints, can achieve agreement on the broad issues facing graduate medical education. Its future effectiveness depends upon how its present problems are resolved and its opportunities for development in the future are managed.

August G. Swanson, M.D.
Director
Department of Academic Affairs
Association of American Medical Colleges

April, 1977

Figure 1

COORDINATING COUNCIL ON MEDICAL EDUCATION

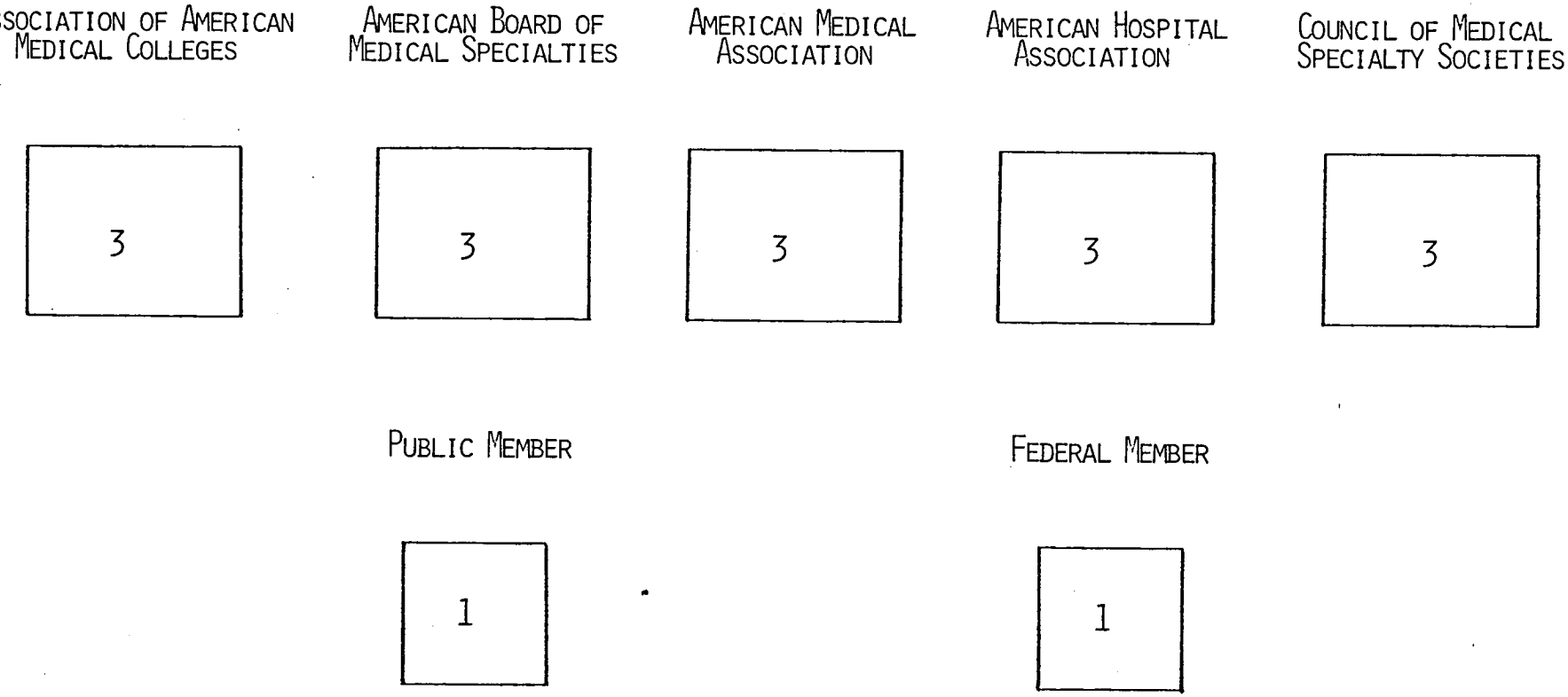


Figure 2

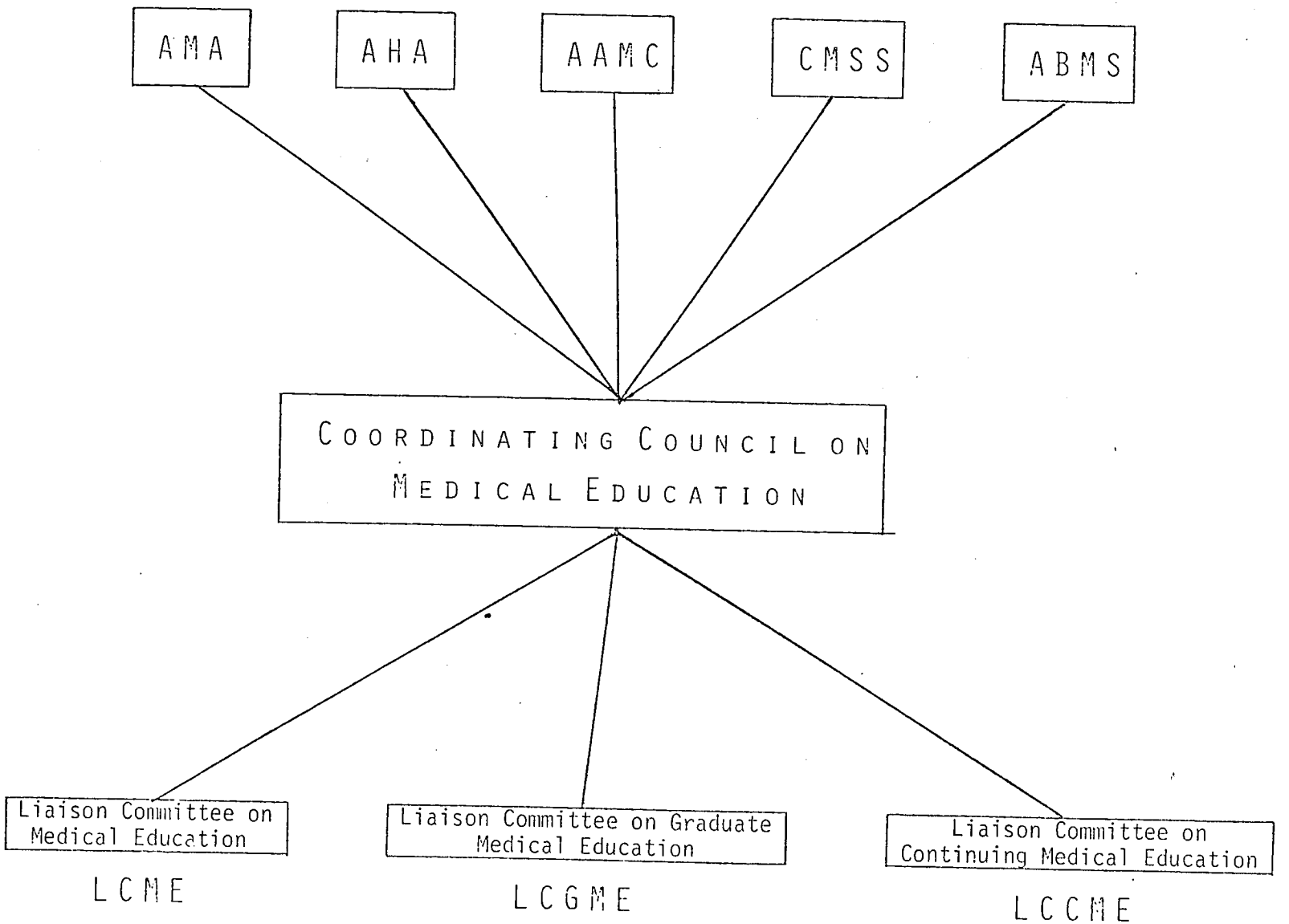


Table 1

AMERICAN BOARD OF MEDICAL SPECIALTIES

American Board of Allergy and Immunology

American Board of Anesthesiology

American Board of Colon and Rectal Surgery

American Board of Dermatology

American Board of Family Practice

American Board of Internal Medicine

American Board of Neurological Surgery

American Board of Nuclear Medicine

American Board of Obstetrics and Gynecology

American Board of Ophthalmology

American Board of Orthopaedic Surgery

American Board of Otolaryngology

American Board of Pathology

American Board of Pediatrics

American Board of Physical Medicine and Rehabilitation

American Board of Plastic Surgery

American Board of Preventive Medicine

American Board of Psychiatry and Neurology

American Board of Radiology

American Board of Surgery

American Board of Thoracic Surgery

American Board of Urology

Table 1

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

American Academy of Dermatology

American Academy of Family Physicians

American Academy of Neurology

American Academy of Ophthalmology and Otolaryngology

American Academy of Orthopaedic Surgeons

American Academy of Pediatrics

American Academy of Physicial Medicine and Rehabilitation

American Association of Neurological Surgeons

American College of Obstetricians and Gynecologists

American College of Physicians

American College of Preventive Medicine

American College of Radiology

American College of Surgeons

American Psychiatric Association

American Society of Anesthesiologists

American Society of Colon and Rectal Surgeons

American Society of Plastic and Reconstructive Surgeons

American Urological Association

College of American Pathologists

Society of Thoracic Surgeons

Table 2

1977 REPRESENTATIVES TO THE
LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

American Board of Medical Specialties

James A. Clifton, M.D.	Dept. of Internal Medicine, University of Iowa, Iowa City, Iowa 52242
William K. Hamilton, M.D.	Dept. of Anesthesiology, 436S, U. of California Med. Center, San Francisco, CA 94143
Victor C. Vaughan, III, M.D.	St. Christopher's Hospital, 2600 North Lawrence Street, Philadelphia, Pennsylvania 19133

American Hospital Association

Mr. Irvin G. Wilmot	New York U. Medical Center, 400 East 34th Street, New York, New York 10016
Mr. Eugene L. Staples	West Virginia University Medical Center, Morgantown, West Virginia 26506

American Medical Association

Richard G. Connar, M.D.	1 Davis Boulevard - Suite 703, Tampa, Florida 33606
Russell S. Fisher, M.D. (Chairman)	111 Penn Street, Baltimore, Maryland 21201
Gordon H. Smith, M.D.	345 Mt. Shasta Drive, San Raphael, California 95819

Association of American Medical Colleges

Thomas K. Oliver, Jr., M.D.	University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania 15213
Robert M. Heyssel, M.D.	Johns Hopkins Hospital, 601 North Broadway, Baltimore, Maryland 21205
James A. Pittman, M.D.	University of Alabama School of Medicine, University Station, Birmingham, Alabama 35294
August G. Swanson, M.D.	AAMC, One Dupont Circle, N.W., Suite 200, Washington, D.C. 20036

Table 2

LCGME REPRESENTATIVES

Council of Medical Specialty Societies

Truman G. Schnabel, Jr., M.D.	Veterans Administration Hospital, Woodland & University Avenues, Philadelphia, PA 19104
Anne M. Seiden, M.D.	1140 S. Paulina Street, Chicago, Illinois 60612

Federal Government Representative

Robert F. Knouss, M.D.	Center Building, 4DF046, 3700 East-West Highway, Hyattsville, Maryland 20782 Bureau of Health Manpower

House Staff Representative

Ralph M. Stanifer, M.D.	U. of Michigan University Hospital, 1425 North Hospital Drive, Ann Arbor, MI 48104

Table 3

Committee	Sponsoring Organizations	Number of Members
Otolaryngology	Council on Medical Education American Board of Otolaryngology American College of Surgeons	12
Pathology	Council on Medical Education American Board of Pathology	6
Pediatrics	Council on Medical Education American Board of Pediatrics American Academy of Pediatrics	9
Physical Med. & Rehab.	Council on Medical Education American Board of Physical Med. & Rehab.	6
Plastic Surgery	Council on Medical Education American Board of Plastic Surgery American College of Surgeons	9
Preventive Medicine	Council on Medical Education American Board of Preventive Medicine	8
Psychiatry & Neurology	Council on Medical Education American Board of Psychiatry & Neurology	12
Radiology	Council on Medical Education American Board of Radiology	8
Surgery	Council on Medical Education American Board of Surgery American College of Surgeons	12
Thoracic Surgery	Council on Medical Education American College of Surgeons American Board of Thoracic Surgery	9
Urology	Council on Medical Education American Board of Urology American College of Surgeons	9

Table 3

RESIDENCY REVIEW COMMITTEES

Committee	Sponsoring Organizations	Number of Members
Allergy & Immunology	Council on Medical Education American Board of Allergy & Immunology	8
Anesthesiology	Council on Medical Education American Board of Anesthesiology	6
Colon & Rectal Surgery	Council on Medical Education American Board of Colon & Rectal Surgery American College of Surgeons	6
Dermatology	Council on Medical Education American Board of Dermatology	4
Family Practice	Council on Medical Education American Board of Family Practice American Academy of Family Practice	9
General Practice	Council on Medical Education American Academy of Family Practice	6
Internal Medicine	Council on Medical Education American Board of Internal Medicine American College of Physicians	12
Neurological Surgery	Council on Medical Education American Board of Neurological Surgery American College of Surgeons	6
Nuclear Medicine	Council on Medical Education American Board of Nuclear Medicine	6
Obstetrics-Gynecology	Council on Medical Education American Board of Obstetrics-Gynecology American College of Obstetrics-Gynecology	9
Ophthalmology	Council on Medical Education American Board of Ophthalmology	6
Orthopedic Surgery	Council on Medical Education American Board of Orthopedic Surgery American Academy of Orthopedic Surgery	9

VI. Liaison with CAS Member Organizations

The Executive Council reviewed a proposal which had been presented by the Association of Professors of Medicine to establish an APM office within the administrative framework of the AAMC. Dr. Bennett reviewed the Executive Committee's discussion of this proposal, which had generally favored a positive response with several cautions. The Committee warned that the Association must operate at the congruence of the educational issues confronting the medical centers, and could not compromise this institutional view for disciplinary interests. However, the Committee recognized the AAMC's special responsibility to the small "chairmen's" societies and the desirability of fostering closer relations and the AAMC's institutional perspective within each of these groups.

The APM proposal reflected a desire to establish Washington representation, closer ties to the AAMC, and a secretariat to handle meeting arrangements and coordinate publications. It was agreed that the staff should pursue possible arrangements with the APM to achieve the latter two objectives. The concept of Washington representation was to be handled through regular contacts with the professional staff of the Association.

It was agreed that the APM should serve as a prototype of future liaisons with CAS chairmen's organizations. The Association would try to arrange a package of services and interactions at a cost which was within the reach of the APM. The Council asked that the staff carefully track the investment of Association resources so that the cost-effectiveness of the arrangement could be assessed after an initial period of time.

The Council members specifically cautioned that this arrangement must clearly differentiate the provision of secretarial and logistic support from the expectation of a special entree into AAMC policy deliberations. It was agreed that the staff would negotiate this carefully circumscribed arrangement with APM officers and report back to the Executive Council in June.

CAS BRIEF DISTRIBUTION

		Total
Member Societies Currently Reproducing & Distributing		6740
American Physiological Society	6000	
Teachers of Family Practice	400	
Pathology Chairmen	110	
Microbiology Chairmen	100	
Association for Med Sch Pharmacology	130	
Member Societies Currently Purchasing from AAMC at Cost		950
Pediatric Department Chairmen	140	
American Academy Orthopedic Surgeons	110	
American Pediatric Society	700	
Member Societies Interested in Obtaining if Available at		
No Cost		1920
Assoc Chairmen Depts. Physiology	120	
Central Society for Clinical Research	1000	
Society of Critical Care Medicine	700	
Association of Academic Physiatrists	100	
1¢ Per Copy		
Assoc of Teachers of Preventive Med	700	1675
Assoc for Academic Psychiatry	300	
Assoc of University Radiologists	675	
2¢ Per Copy		
Assoc University Profs of Neurology	100	7060
Amer Federation for Clinical Research	100	
Assoc University Profs Ophthalmology	100	
Acad Clin Lab Physicians & Scientists	400	
Amer Assoc of Plastic Surgeons	225	
Society for Chrmn Acad Radiology Depts	135	
American Academy of Neurology	6000	
		18,345

Member Societies Undecided, Will Consider at Later Date

American Urological Association, Inc.
Association of Professors of Medicine
American College of Obstetricians & Gynecologists
American Surgical Association

Member Societies Eliciting No Response

American Academy of Allergy
Association of Anatomy Chairmen
Association of University Anesthetists
American Society of Biological Chemists, Inc.

Association of Medical School Departments of Biochemistry
American Association for the Study of Liver Diseases
American Society for Clinical Investigation, Inc.
American Society for Clinical Nutrition
Southern Society for Clinical Investigation
Association of Professors of Dermatology
Endocrine Society
American Gastroenterological Association
American College of Physicians
Society of University Surgeons
American Neurological Association
Society of Surgical Chairmen
Association of Professors of Gynecology and Obstetrics
Society for Gynecologic Investigation
Society of University Otolaryngologists
Association of Orthopaedic Chairmen
American Society of Clinical Pathologists
Society for Pediatric Research
American Society for Plastic and Reconstructive Surgeons
Plastic Surgery Research Council
American Association of Chairmen of Departments of Psychiatry
American Association for Thoracic Surgery

Member Societies Not Interested in Providing Copies

American Association of Anatomists
Society of Academic Anesthesia Chairmen
Association of American Physicians
Society of University Urologists
American Association of Neurological Surgeons
American Academy of Ophthalmology and Otolaryngology (to Officers only)

Member Societies Interested but Unable to Distribute on Regular Basis

Association for Academic Surgery

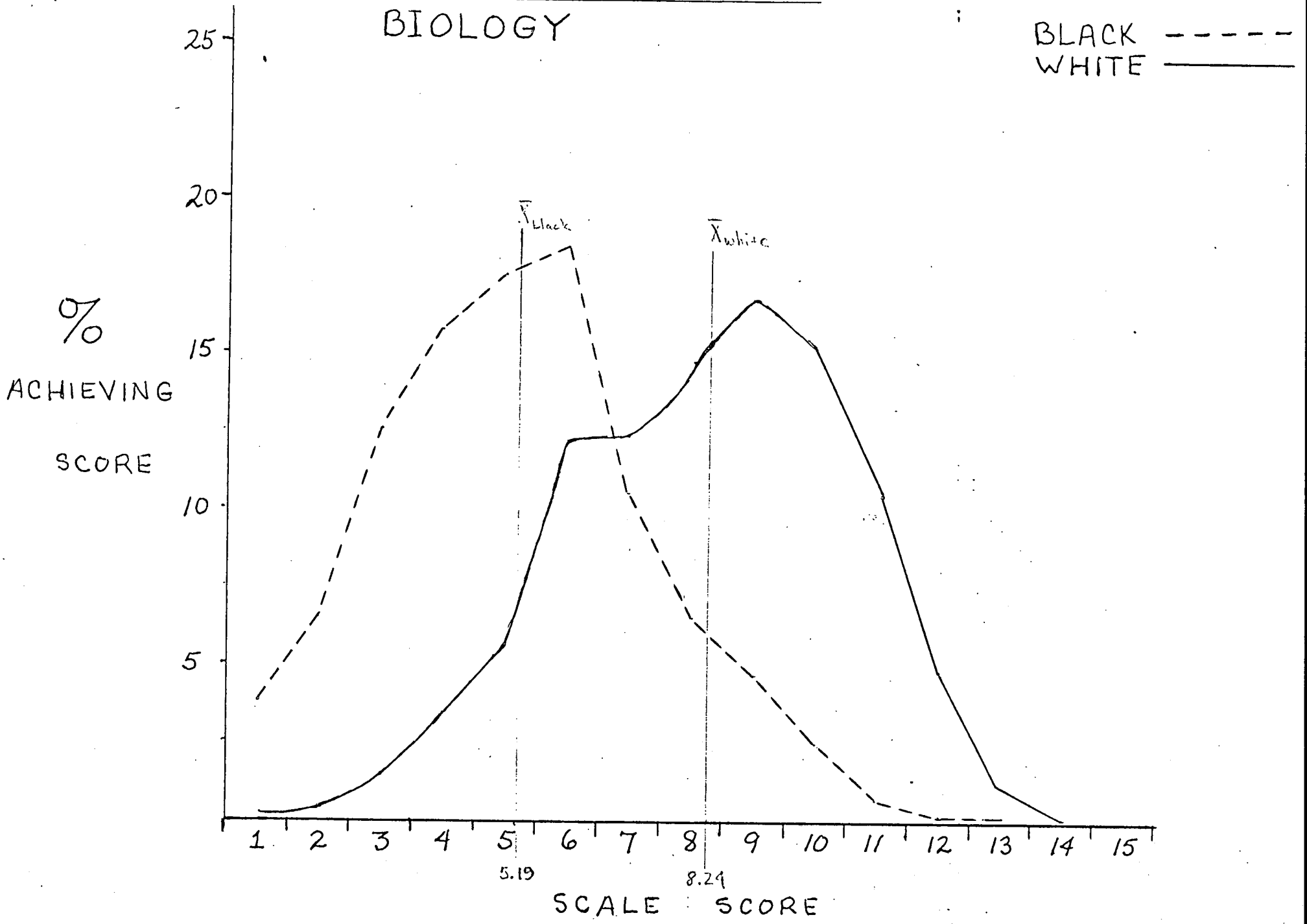
COMPARISON OF MEAN GPAs AND MCAT SCORES OF BLACK AND WHITE APPLICANTS 1973-1977

	1977			1976			1975			1974			1973		
GPA	White	Black	Δ	White	Black	Δ	White	Black	Δ	White	Black	Δ	White	Black	Δ
SCIENCE	NA	NA	NA	3.28	2.55	1.43	3.23	2.54	1.35	3.19	2.51	1.33	3.10	2.45	1.27
OTHER	NA	NA	NA	3.38	2.93	1.02	3.33	2.90	0.98	3.27	2.86	0.93	3.18	2.79	0.89
TOTAL	NA	NA	NA	3.32	2.72	1.40	3.28	2.70	1.35	3.23	2.67	1.30	3.14	2.62	1.21
MCAT															
SCIENCE	--	--	--	587	450	1.37	580	436	1.44	569	431	1.38	559	424	1.35
QA	--	--	--	603	474	1.29	594	465	1.29	584	454	1.30	581	449	1.32
VA	--	--	--	552	439	1.13	552	440	1.12	544	435	1.09	544	441	1.03
GI	--	--	--	538	445	0.93	537	439	0.98	542	441	1.01	544	446	0.98
NEW MCAT															
BIOLOGY	8.24	5.19	1.22												
CHEMISTRY	8.27	5.25	1.21												
PHYSICS	8.25	5.41	1.14												
SCI. PROB.	8.32	5.06	1.30												
READING	8.38	5.18	1.28												
QUANT.	8.40	4.61	1.52												

$\Delta = \frac{\text{White - Black}}{\text{s.d.}}$

Standard Deviations (approximate): GPA Science = .51
Other = .44
Total = .43
MCAT = 100
New MCAT = 2.5

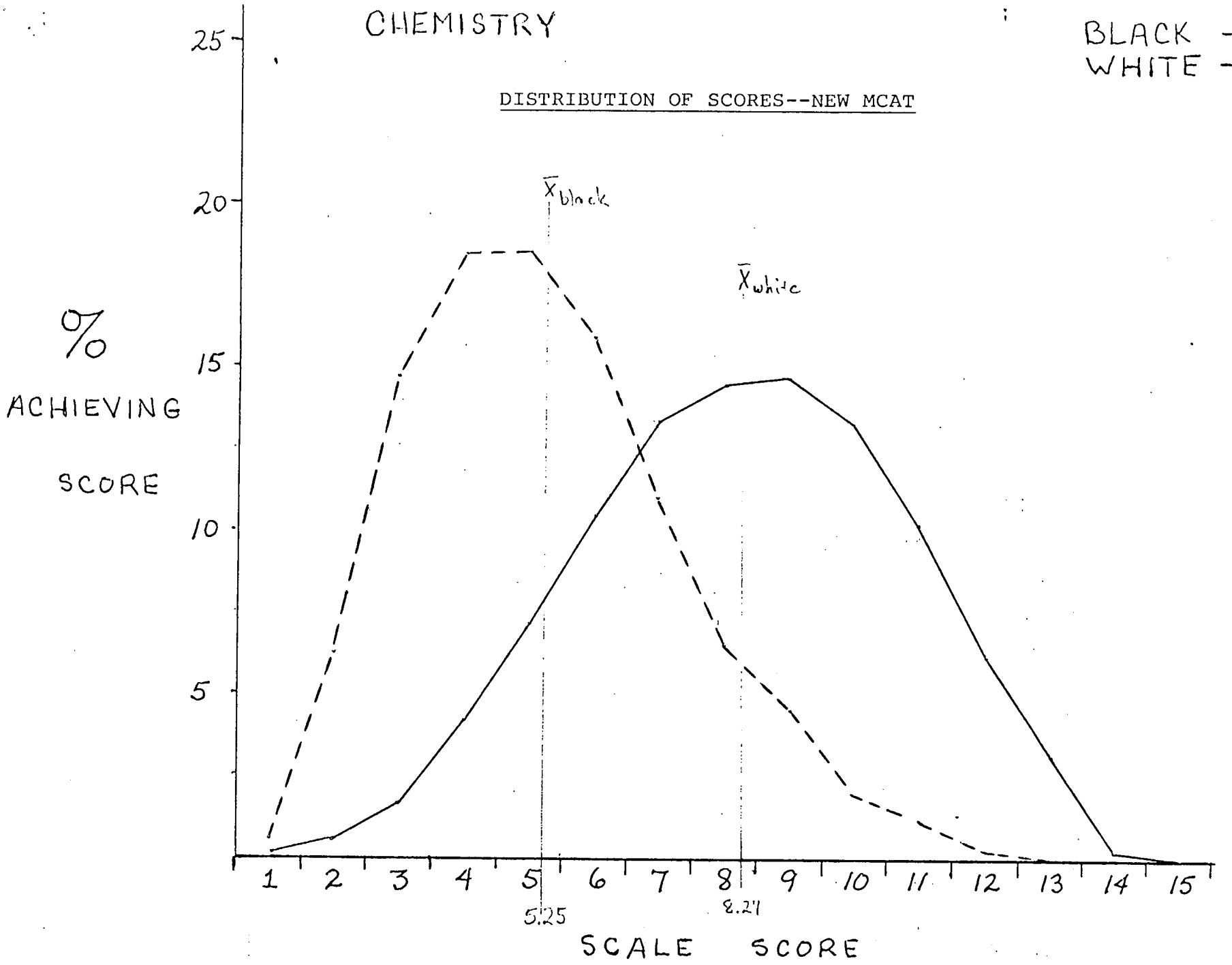
DISTRIBUTION OF SCORES--NEW MCAT

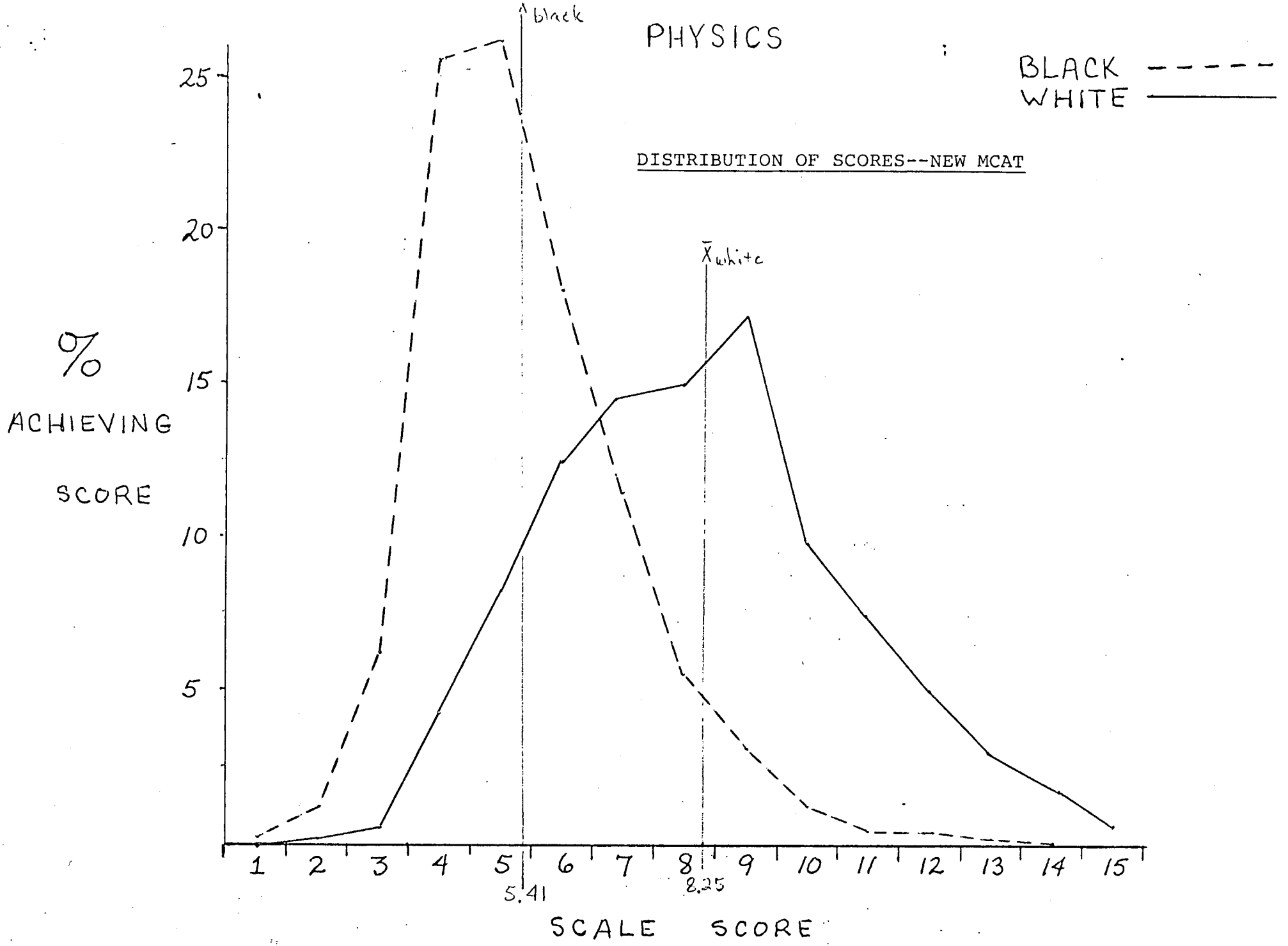


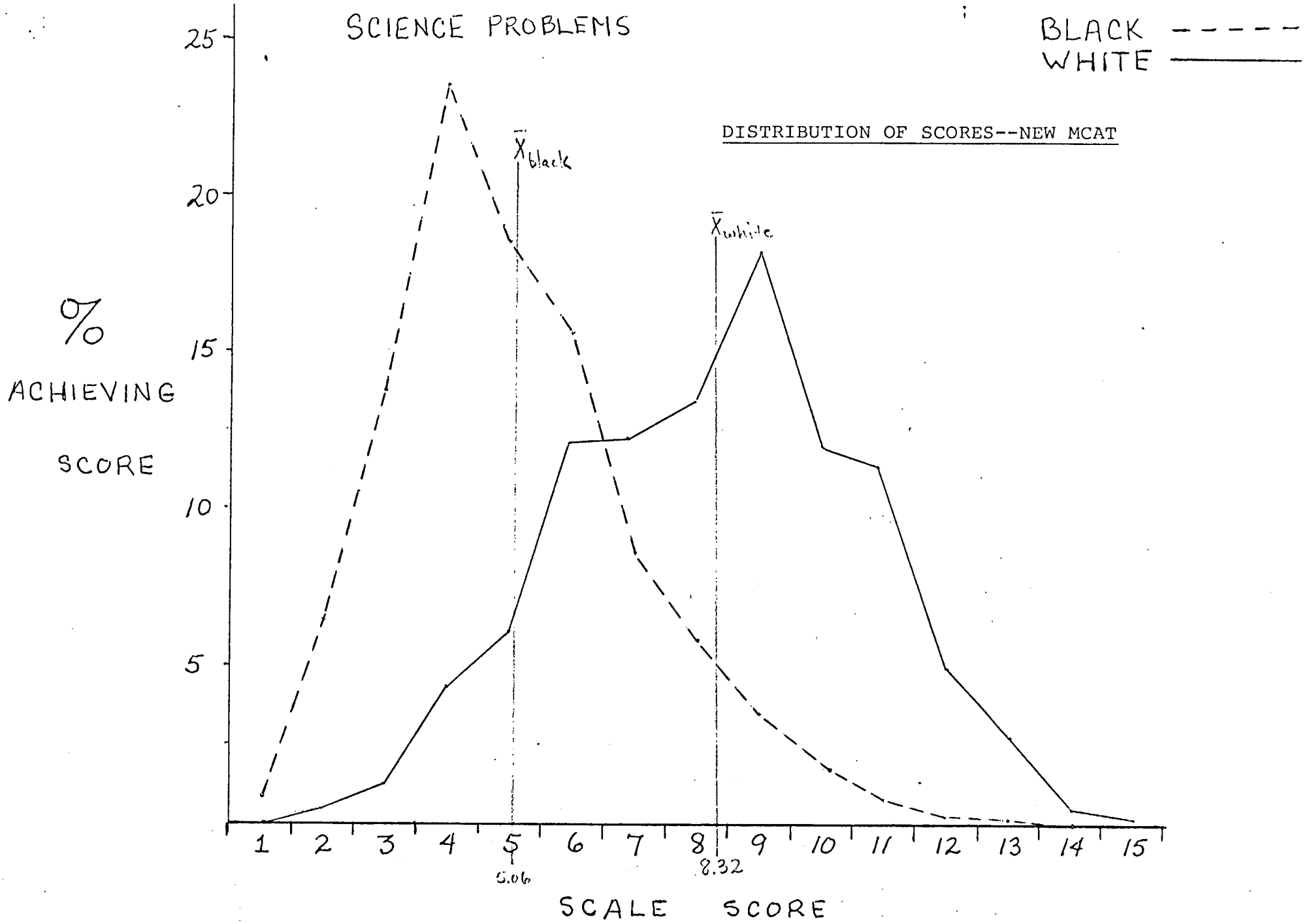
CHEMISTRY

BLACK - - - - -
WHITE ———

DISTRIBUTION OF SCORES--NEW MCAT







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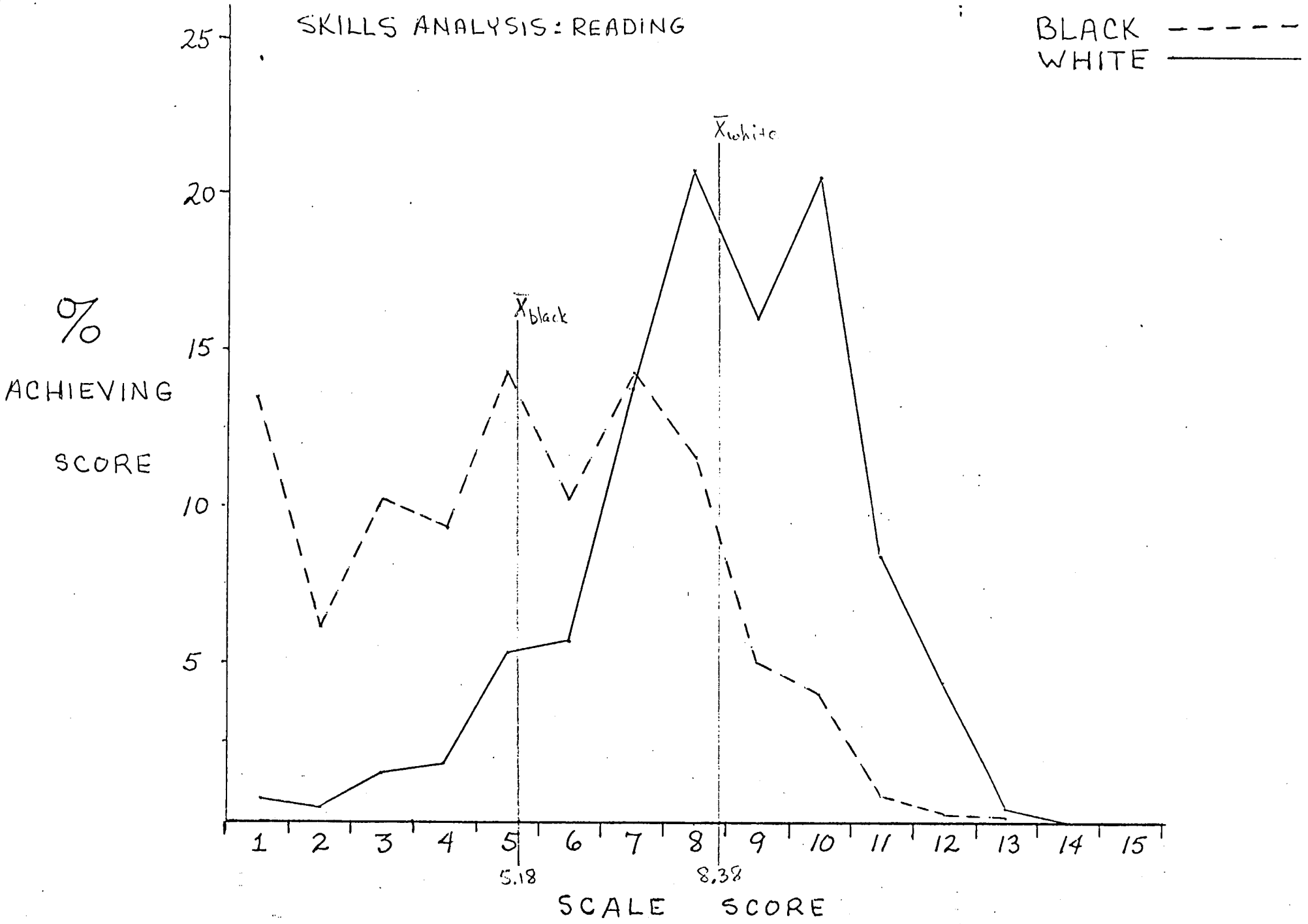

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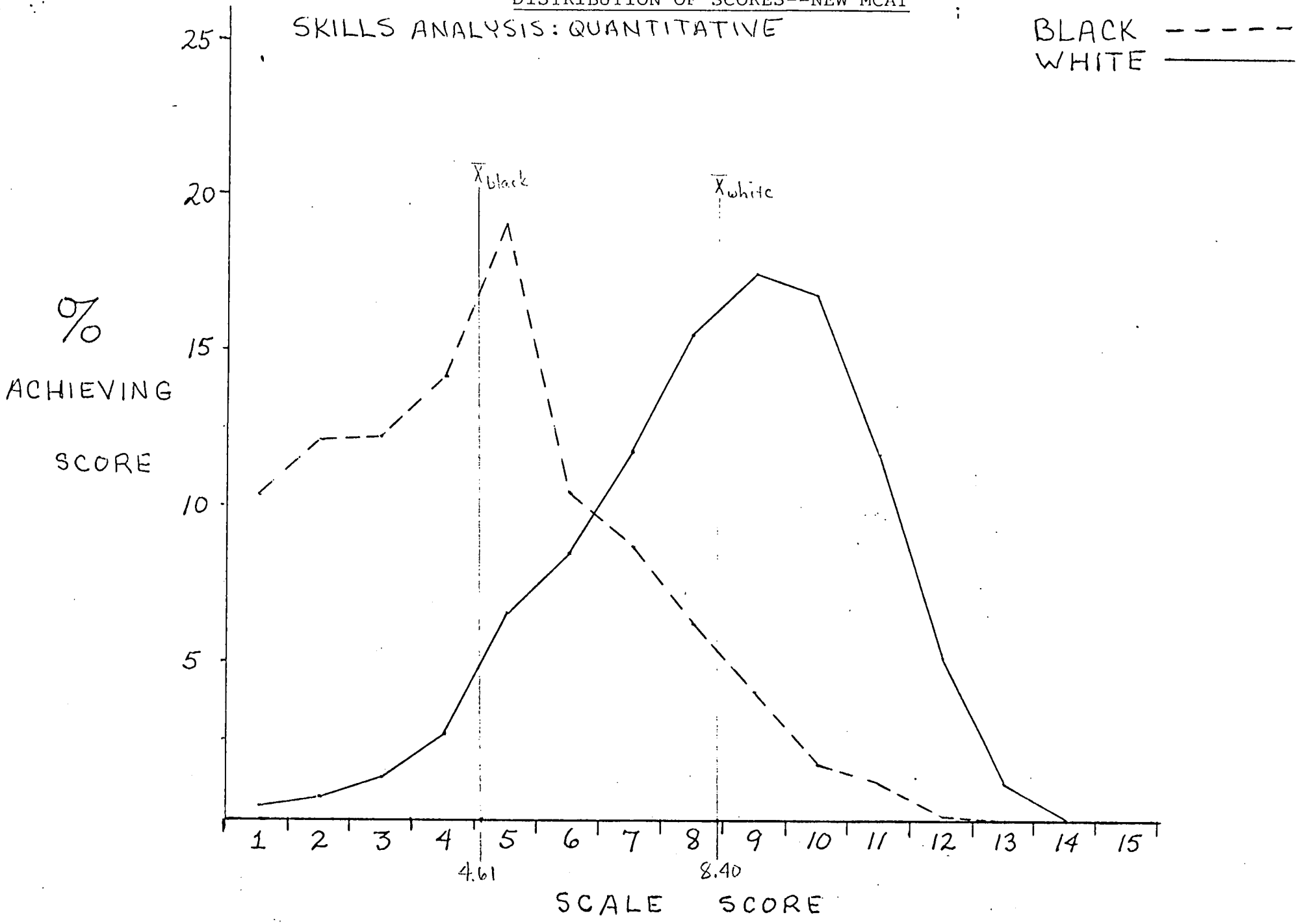

RACIAL BACKGROUND	PARENTAL INCOME	APPLICANTS NO.	APPLICANTS MEAN	ACCEPTEES NO.	ACCEPTEES MEAN
CAUCASIAN/WHITE	$10,000+	27,139	3.34	11,021	3.55
	<$10,000	3,191	3.27	1,006	3.54
UNDERREPRESENTED MINORITIES	$10,000 +	1,725	2.80	757	3.00
	<$10,000	1,238	2.79	462	3.02

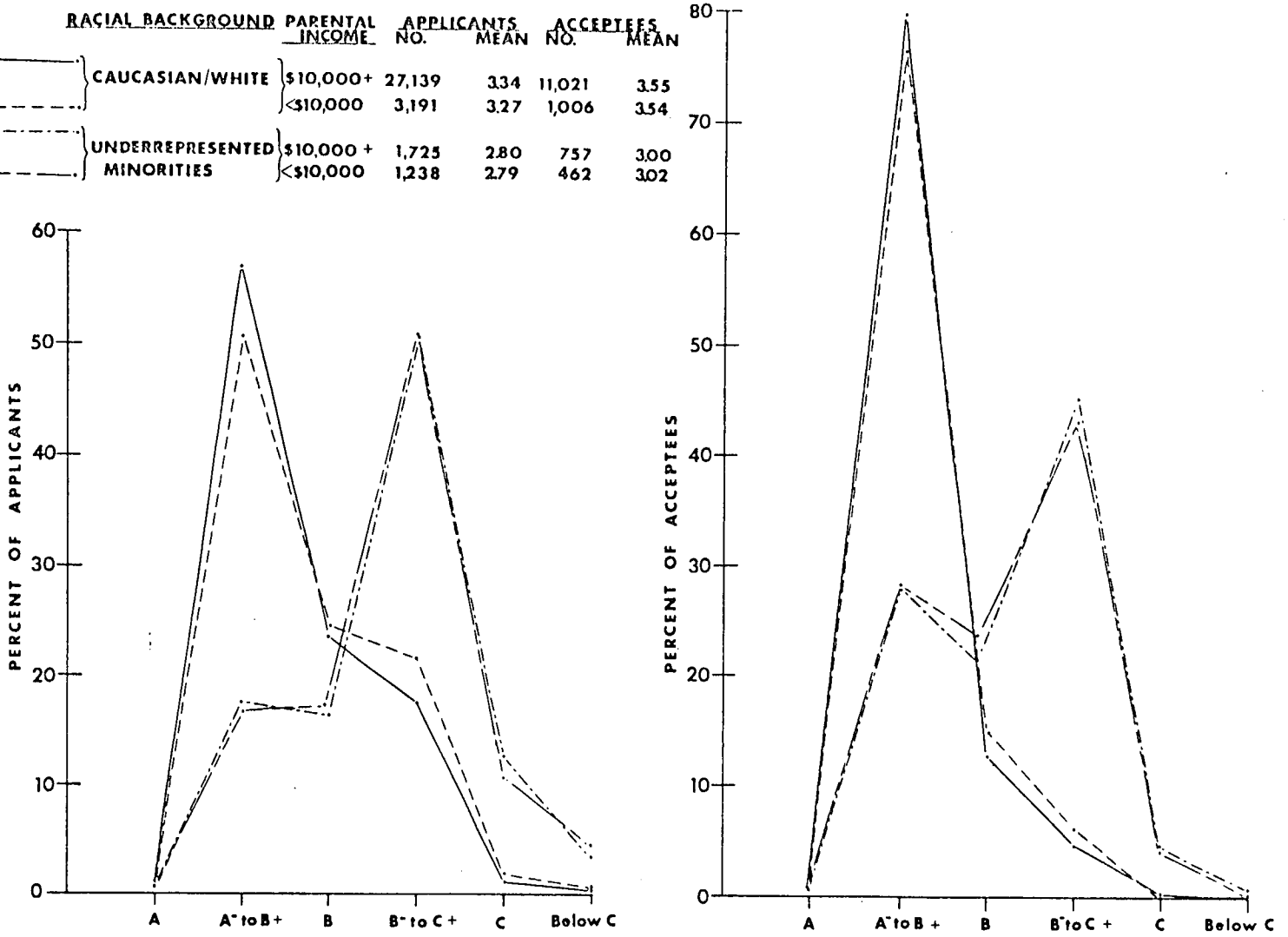

FIGURE 1

UNDERGRADUATE GPA's OF APPLICANTS AND ACCEPTEES TO 1976-77 ENTERING CLASS OF U.S. MEDICAL SCHOOLS (BY RACE & PARENTAL INCOME)

RACIAL BACKGROUND	PARENTAL INCOME	APPLICANTS		ACCEPTEES	
		NO.	MEAN	NO.	MEAN
CAUCASIAN/WHITE	$ 10,000 +	29,235	553	11,680	582
	< $10,000	3,527	548	1,080	580
UNDERREPRESENTED MINORITIES	$ 10,000+	1,965	466	814	502
	< $10,000	1,416	438	505	471

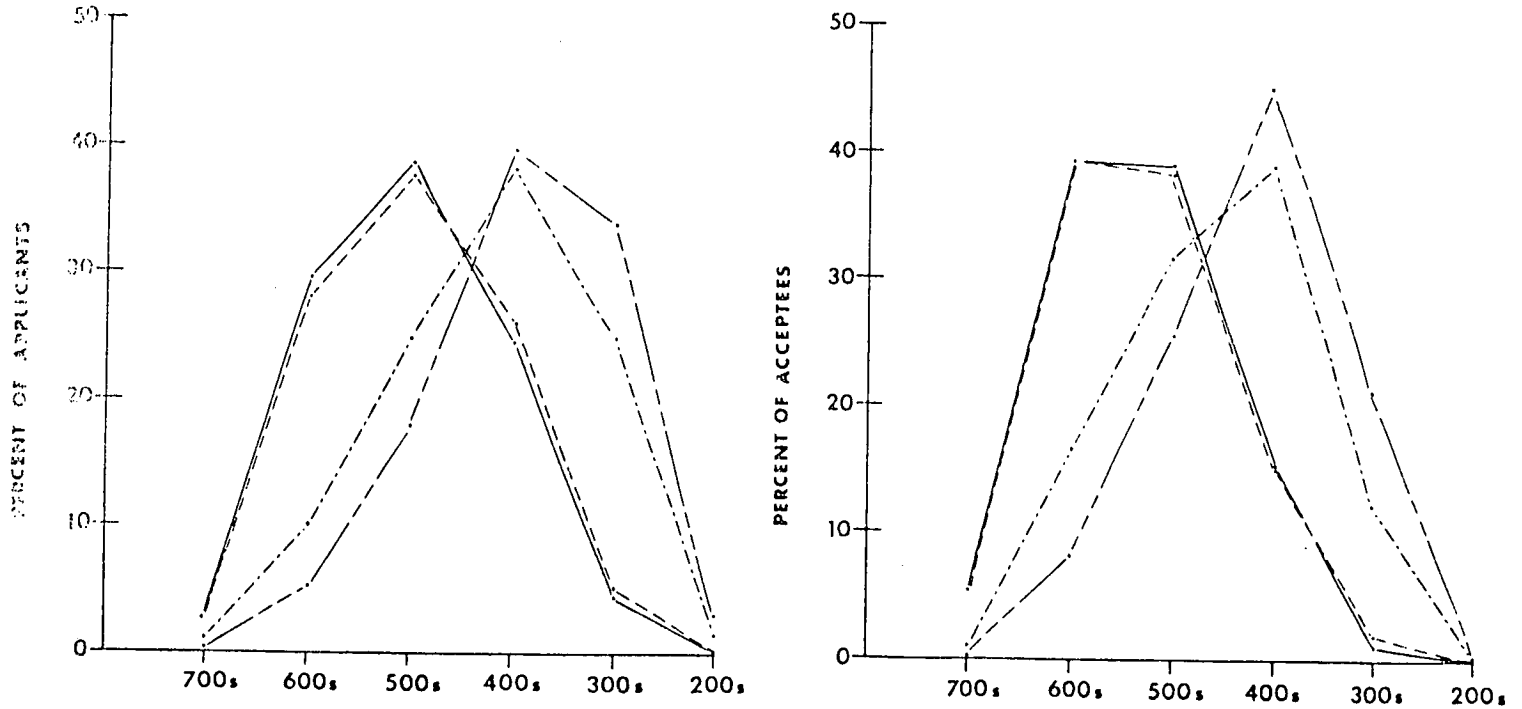

FIGURE 2

VERBAL ABILITY MCAT SCORES OF APPLICANTS AND ACCEPTEES TO 1976-77 ENTERING CLASS OF U.S. MEDICAL SCHOOLS (BY RACE AND PARENTAL INCOME)

RACIAL BACKGROUND	PARENTAL INCOME	APPLICANTS		ACCEPTEES	
		NO.	MEAN	NO.	MEAN
CAUCASIAN/WHITE	$ 10,000 +	29,235	605	11,680	645
CAUCASIAN/WHITE	<$10,000	3,527	584	1,080	631
UNDERREPRESENTED MINORITIES	$ 10,000 +	1,965	502	814	542
UNDERREPRESENTED MINORITIES	<$10,000	1,416	479	505	525

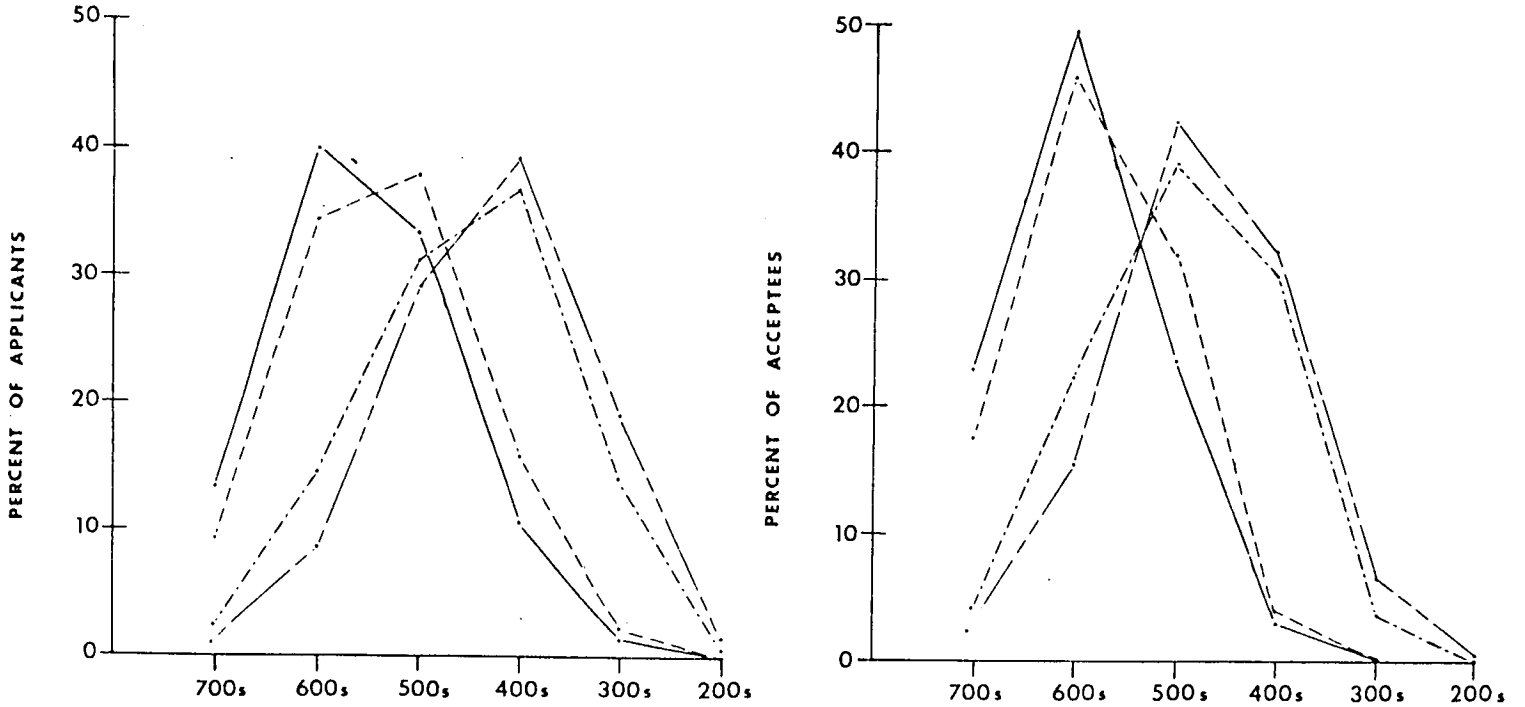

FIGURE 3

QUANTITATIVE ABILITY MCAT SCORES OF APPLICANTS AND ACCEPTEES TO 1976-77 ENTERING CLASS OF U.S. MEDICAL SCHOOLS (BY RACE & PARENTAL INCOME)

RACIAL BACKGROUND	PARENTAL INCOME	APPLICANTS NO.	APPLICANTS MEAN	ACCEPTEES NO.	ACCEPTEES MEAN
CAUCASIAN/WHITE	$10,000 +	29,235	539	11,680	557
	< $10,000	3,527	533	1,080	555
UNDERREPRESENTED MINORITIES	$10,000 +	1,965	469	814	490
	< $10,000	1,416	446	505	467

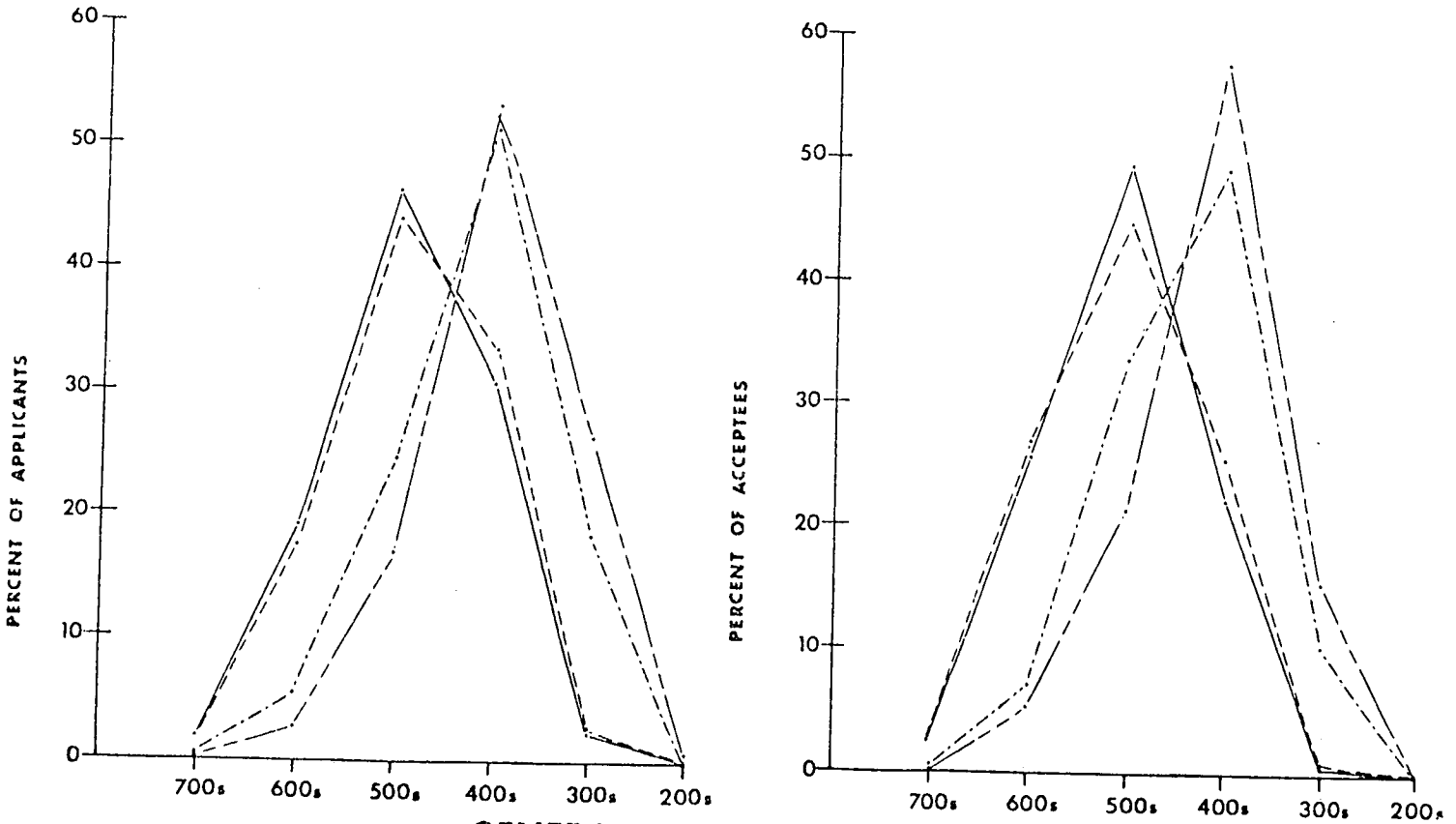

FIGURE 4

GENERAL INFORMATION MCAT SCORES OF APPLICANTS AND ACCEPTEES TO 1976-77 ENTERING CLASS OF U.S. MEDICAL SCHOOLS (BY RACE & PARENTAL INCOME)

RACIAL BACKGROUND	PARENTAL INCOME	APPLICANTS NO.	APPLICANTS MEAN	ACCEPTEES NO.	ACCEPTEES MEAN
CAUCASIAN/WHITE	$10,000 +	29,235	589	11,680	629
	<$10,000	3,527	571	1,080	625
UNDERREPRESTED MINORITIES	$10,000 +	1,965	480	814	529
	<$10,000	1,416	456	505	513

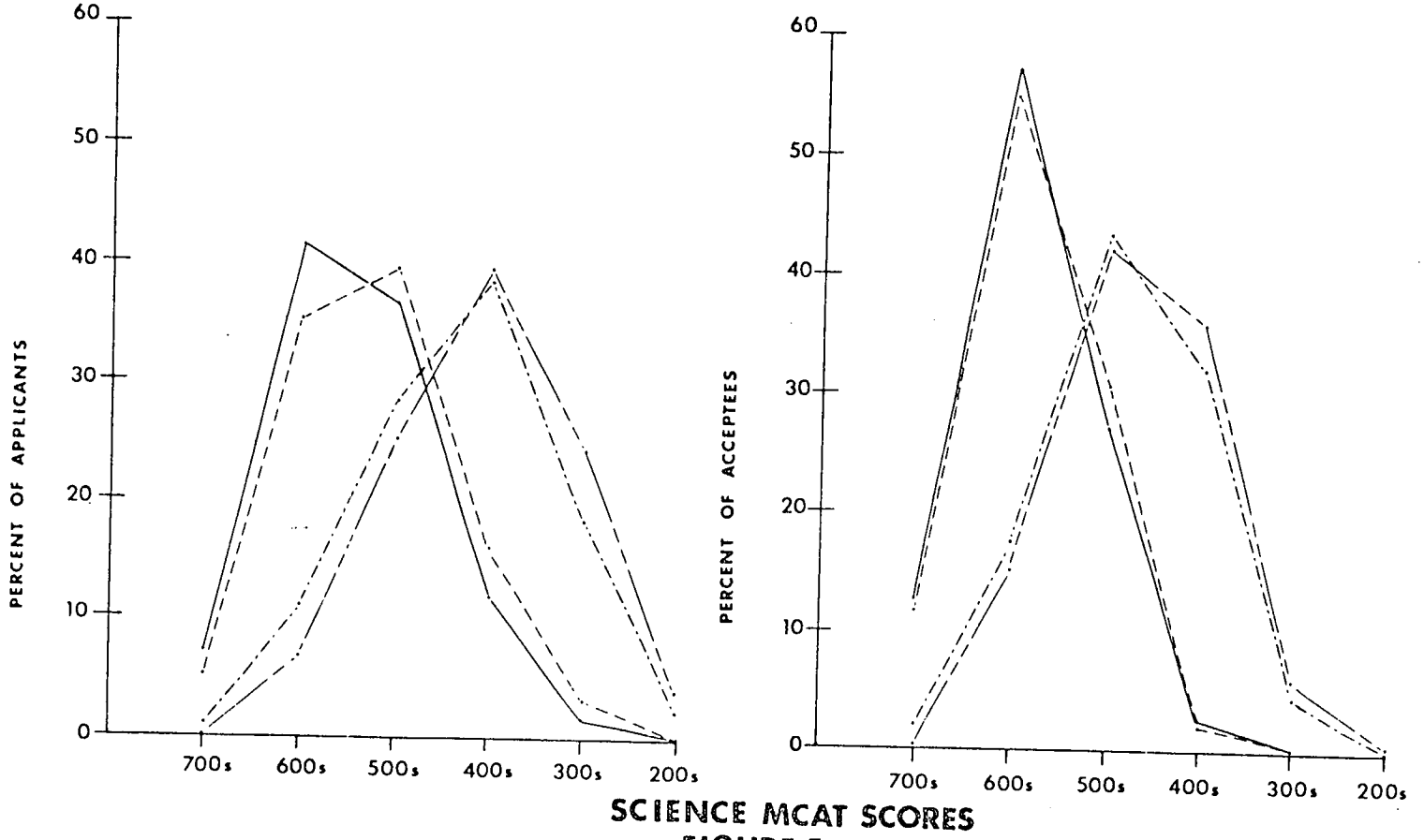

FIGURE 5

SCIENCE MCAT SCORES OF APPLICANTS AND ACCEPTEES TO 1976-77 ENTERING CLASS OF U.S. MEDICAL SCHOOLS (BY RACE AND PARENTAL INCOME)

AAMC POSITION STATEMENT ON THE WITHHOLDING OF SERVICES BY PHYSICIANS

An important national issue has been emphasized by several recent instances where physicians have acted in concert to withhold or restrict medical services. This raises a critical professional question which must be addressed: Is it ethical for physicians to withhold services?

In asking this question, we are asking whether a physician who refuses to provide those services which he is capable, by training, skill and license, of providing, deserves to be judged morally reprobate by colleagues, by the profession and by the public. The answer to the question depends upon a careful deliniation of the circumstances and the reasons alleged to justify the refusal to serve.

An individual physician has no strict obligation in justice to provide medical care to any particular person unless that person can assert a right to that physicians's services. Such a right is established by the fiduciary contract which obtains after a physician agrees to accept the person as a patient. Similarly, such a right is established if the physician enters into a formal agreement to treat a certain class of persons, such as employees of a firm, members of the armed forces, etc. Such a right would be established in law, if this country instituted in a constitutional manner, a civil right to health care and physicians were allowed to practice only on signifying their willingness to accept patients as assigned. Without a legitimate right, there is not duty in justice imposed upon any particular physician. This ethical position underlies the traditional

principle of medical ethics, found in the AMA Principles, "A physician may choose whom he will serve." Once he has made that choice, however, presumably on the basis of a person's request that he do so, a structure of rights and duties is established. It is considered unethical for a physician to terminate that relationship without adequate warning to the patient and assisting the patient to find medical assistance elsewhere. In sum, the strict rights and duties in justice arise from contractual arrangements mutually entered and capable of termination only on condition that the patient is not left alone in his or her need for care. Given these conditions, the question, "is it ethical for a physician to withhold services?" can be answered quite simply. Yes, it is ethical if the physician has not entered a contractual arrangement and, having entered such an arrangement, he has terminated it in a proper manner.

However, strict rights and duties in justice are not the only grounds for ethical assessment of a physician's behavior. Even when duties in justice do not exist, other duties may arise on the grounds of benevolence or humanness, which are ethical principles as compelling as justice. Thus, one trained as a physician, when approached by or encountering someone in immediate need of medical care, has a moral obligation to assist. However, unlike obligations in justice, obligations in benevolence vary greatly in seriousness, depending on circumstances. The seriousness of the need and its urgency, the availability of other help, the inconveniences, risks and losses imposed upon the physician, these and many other considerations determine the weight of the obligation. Thus, a physician on his way to the emergency room who

refuses to assist a stranger who has a trivial complaint is hardly judged derelict in duty. If he bypasses someone obviously choking or suffering cardiac arrest without the most weighty reason, he is judged most seriously derelict and may even incur legal liabilities. This sort of obligation in benevolence rests upon the accepted ethical principle that every human has an obligation to assist those in serious need, when such assistance does not endanger the rescuer in some serious way.

This sort of obligation approaches the obligations is justice as in circumstances where someone in need of medical attention has no recourse to anyone other than a particular physician and when a delay in care would result in a serious detriment. Considerations about payment, about inconvenience to the physician or even personal animosity carry little moral weight in such circumstances. Bohnius, an ancient author on medical ethics, advises us that, while Turks and Jews should be tended by their own physicians, if none of their faith were available, the Christian physician has a moral obligation to care for them, unless he feared that, as a result of his care, they would become strong enough to do him harm on recovery! The case is antiquated, but the principle is clear.

This statement of the moral obligations of physicians is very general; the general principles are applied with difficulty to many real situations. It should be obvious that there are many situations in which other moral principles appear very compelling and indeed overriding. For example, it may happen that a physician, bound by clear responsibilities, finds that his skills are being wrongly used or are contributing to results which can be judged immoral in themselves. For example, police physicians, if asked to

resuscitate prisoners who have been tortured in order to return them to the rack, would have strong ethical justification for refusing to use their medical skills for this purpose.

There are other more perplexing situations. They often arise when question of a "doctor's strike" is broached. In these situations, withholding of medical services will not be the act of an individual physician, but of a group of physicians who are bound by some common interest which they judge will be furthered by the strike. Sometimes, the physicians will be serving under a contract of some sort, as industrial physicians, prison doctors or employees of a hospital; at other times, they will be private physicians who enter into voluntary collaboration to refrain from medical services. The interest which they wish to further may be a personal benefit of increased salary, a professional benefit such as a revision of an unjust malpractice law or relief from heavy malpractice insurance. On the other hand, the interest may be a benefit for others than themselves or their colleagues. It may be institutional concessions in favor of better patient care or improved access to medical care. Usually, both personal gain and patient welfare have been involved.

Further, different forms of withholding service may be employed. Complete refusal to respond to any call for help is exceedingly unusual in these situations. It is more usual to respect obligations in justice by deciding to treat only current patients, but not to receive any others or to respect serious obligations in benevolence by providing care only for emergency cases, while refusing all postponable problems or elective activities. Sometimes, the slowdown or "work to rule" approach can be

used: physicians will fulfill stated standards of care to the letter, thus slowing the accessioning of new patients into the system. The actual way in which all of these factors, status of the physicians, motivations, style or manner of withholding services, flow together in any particular case will have great bearing on the ethical judgment to be made. In addition, the expected impact upon the community as well as the circumstances, such as the availability of alternative care, must be considered in any ethical assessment of the particular situation.

There are salient features which many persons feel are sometimes thought to make a major difference in the ethical evaluation of a doctors' strike. One of the most commonly mentioned is the distinction in motivation. It might be said a strike for the purpose of improving the personal emoluments of an already well to do profession would be totally reprehensible, while a strike to improve dangerous and deficient conditions of patients would be acceptable and even laudable. Indeed, how could anyone fault a strike to demand essential patient services which was organized so as to continue an appropriate level of attention to patients already under care and to provide for emergency services?

It is the position of this Association that, even when prompted by altruistic motives, a doctors' strike is ethically suspect and should be repudiated as a means whereby physicians attempt to modify social, political or economic conditions. Those who would resort to this method must justify their action on the basis of the most extreme conflict with an even higher moral responsibility; for example, declining to be a party to torture. The Association's position rests upon four considerations.

First, the traditional ethics of medicine prescribe that when an individual physician withdraws from a case, he or she should give adequate notice and assure that the patient can obtain care elsewhere. Should the physician be the only available provider, it seems certain that he or she remains under an ethical obligation to continue to treat. However, when physicians act in concert to withhold services, the situation is much changed. The agreement among all physicians in a place or among all specialists of a certain sort to withhold their services would undermine the assumption underlying an ethical withholding of services; namely, that a patient needing care could find it, even if an individual physician were unwilling to provide it. The fundamental ethical obligation (as distinguished from the legal obligation) of those who practice medicine is to serve potential patients. Medical services must be somewhere available and access to them not rendered even more difficult by the actions of physicians. We conclude, therefore, that a concerted action to withhold services, by making care unavailable to potential patients, violates the ethics of the profession.

The second argument against the strike as an ethical tactic open to the medical profession is somewhat similar to the first. It rests upon the fact that, under the licensure laws of this, and most other, nations, physicians are the sole providers of certain sorts of medical care. Indeed, the sorts of care which they have the skills to provide are those which touch the more serious threats to health and life. If they withhold those services, no substitutes are available. Although any strike imposes

hardships on some segment of the public, those affected can almost always find an alternative for the product or service of which they are deprived. However, a strike of doctors leaves no alternative sources for certain serious or potentially serious needs. It may be said that this argument only supports the ethical imperative of continuing emergency services. However, the needs of the chronically ill, while not "emergent" can be serious; the failure to treat rapidly an infection can lead to serious consequences. We conclude that the unique capability of physicians to provide assistance to serious needs constitutes a reason sufficient to repudiate the strike as an ethical tactic.

Further, in even the altruistic strike, the willingness to treat only certain sorts of patients, those with certain needs, depends on the physicians' determination of what needs are worthy of his attention. However, the ethical basis of medicine is the readiness to accept needs as the patient defines them and brings them. Needless to say, once many needs are examined, it is found that the physician can do little or nothing about them and indeed, under examination, they may evaporate. Still, the readiness to allow persons to present themselves with their own definition of the problems which compel them to come, is the essential ethical basis of medicine. The activities of reassurance, assuagement of doubt, support, alleviation of symptoms are as important to medicine as staunching an exsanguinating hemorrhage. The strike as an accepted mode of physician behavior, even with the highest motives, negates the principle of readiness and the principle of the patient's self-definition. If the strike is, in principle, a repudiation of the ethical basis of medicine, it ought to lie outside the range of behavior which physicians call ethically appropriate for themselves.

The foregoing reasons, the readiness to serve potential patients, the unique services of the profession, lead to another consideration. The public has come to trust that these features characterize the medical profession. The public thinks of the medical profession as made up of persons who have certain skills not elsewhere available and who offer themselves as ready to accept those who seek those skills. They have confidence that this is the nature of the profession, and are frustrated when they discover, in particular cases, that one or another of these features is lacking. That public confidence supports the existence of medical licensure laws and concedes to the profession the considerable autonomy and privilege which it enjoys. But these concessions by the public call for a reciprocal response by the profession; that they refrain from the exercise of a potentially powerful technique available to others in society, not withholding services.

The physicians' strike disappoints the public confidence. It violates the "trust" arising from that confidence. At present, the consequences of such a violation are small, since the public seems loath to punish physicians as a class and unready to repeal the legal statutes which provide the profession with an extraordinary scope of self government. But, if physicians regularly resort to strikes, there unquestionably will be an erosion of that confidence. Ultimately, the profession, though it may seem to have won some small victories, will be stripped of its privileged status or that status will be surrounded by major constraints. The profession, however, will not be the worst loser: the people who deserve the service of a trustworthy profession will suffer the most.

A final consideration acknowledges the claim, made by some physicians who favor the strike, not for selfish reasons, but for altruistic ones. They assert that physicians have important social responsibilities, which they are obliged, on occasion, to fulfill by withholding services. Only in this manner, they allege, can they move an entrenched bureaucracy to improve conditions of patient care. This Association agrees that physicians do have significant social responsibilities. They have the education and experience which enable them to contribute important insights about the health and well-being of the population. They have a responsibility to speak and act in concert to promote the public good, but in doing so should use those means available to them in their capacity as informed and involved citizens. However, the primary responsibility is the one which they manifest to the public by accepting the role of healer. It is inappropriate to attempt to fulfill one's social responsibilities by acting in ways which are detrimental to this primary responsibility of caring for the sick. That care is, first and foremost, ministering to their physical and psychological needs; only while this is being done, should physicians urge those changes in social and economic conditions which they believe will contribute to better patient care.

This negative position on physicians' "right to strike" does not deny that there are many situations which need to be put right and that often it is possible that physicians themselves might be quite unfairly treated by the public, by employers or by government. Society is readily tempted to take unfair advantage of those who are bound by obligations to serve: budget cuts often fall first on public employees because they are most

vulnerable. The repudiation of a tactic which is open to those who are employed in industry and commerce is the price the profession must pay for continued public acceptance and esteem. However, that price does not include unfair or disabling conditions of practice nor does it require acceptance of unsafe or degrading conditions of treatment of patients. It is absolutely essential, indeed, it is demanded in justice, that those who take the ethical stance that they will not strike need be provided with means for redress of grievances and a means to modify conditions which they honestly judge unfair or inhumane. Therefore, society should respond to this voluntary restraint of physicians by providing a fair process for resolving economic and organizational issues which influence the welfare of the profession and the quality of medical care.

September 14, 1977

DRAFT

THE ESSENTIALS OF GRADUATE MEDICAL EDUCATION

prepared and submitted by the

Committee on Essentials

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FOREWORD

THE COORDINATING COUNCIL ON MEDICAL EDUCATION AND ITS LIAISON COMMITTEES

The Coordinating Council on Medical Education (CCME)* was established in 1973 through the agreement of five sponsoring professional organizations. These are the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), and the Council of Medical Specialty Societies (CMSS). Each organization has three seats on the Council.

The Coordinating Council is responsible for coordinating the activities of the three Liaison Committees which have accreditation authority over the undergraduate, graduate, and continuing phases of medical education. The Council also reviews and perfects major policy recommendations and submits agreed-to changes in policy to the five sponsoring organizations, all of which must give approval to policies before they are implemented.

Accreditation of undergraduate medical education is the responsibility of the Liaison Committee on Medical Education (LCME), which was established in 1942. The Association of American Medical Colleges and the American Medical Association each have six seats on the LCME; in addition, there are two public members and a representative of the federal government.

The Liaison Committee on Graduate Medical Education (LCGME) was formally implemented in 1975. The Association of American Medical Colleges, the American Board of Medical Specialties and the American Medical Association each have four seats on the LCGME. The American Hospital Association and the Council of Medical Specialty Societies each have two seats. In addition, there are one public member, one resident physician member, and a representative of the federal government.

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*The address of the Coordinating Council is: Coordinating Council on Medical Education, Office of the Secretary, P.O. Box 7586, Chicago, Illinois 60610

The Liaison Committee on Continuing Medical Education (LCCME) was formally implemented in 1977. The American Medical Association has four seats on the LCCME. The Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies each have three seats. The Association of Hospital Medical Educators and the Federation of State Medical Boards each have one seat. In addition, there are one public member and a representative of the federal government.

Each Liaison Committee has accreditation policies and procedures germane to the phase of medical education for which it is responsible.

The Liaison Committee on Graduate Medical Education oversees the policies and procedures of the several Residency Review Committees (RRCs) and after review of RRC recommendations issues letters of accreditation to approved programs and their institutions. The LCGME is also responsible for the development of the policies set forth in the General Requirements for Graduate Medical Education and implements those policies after approval by the five sponsoring professional organizations.

The LCGME also reviews and approves the Special Requirements developed by each Residency Review Committee. The RRCs submit these to the LCGME after they have been reviewed and approved by the sponsors of the RRC. The Residency Review Committees and their sponsors are:

RRC	Sponsoring Organization
Allergy & Immunology	AMA Council on Medical Education American Board of Allergy & Immunology
Anesthesiology	AMA Council on Medical Education American Board of Anesthesiology
Colon & Rectal Surgery	AMA Council on Medical Education American Board of Colon & Rectal Surgery American College of Surgeons

RRC	Sponsoring Organization
Dermatology	AMA Council on Medical Education American Board of Dermatology
Family Practice	AMA Council on Medical Education American Board of Family Practice American Academy of Family Practice
General Practice	AMA Council on Medical Education American Academy of Family Practice
Internal Medicine	AMA Council on Medical Education American Board of Internal Medicine American College of Physicians
Neurological Surgery	AMA Council on Medical Education American Board of Neurological Surgery American College of Surgeons
Nuclear Medicine	AMA Council on Medical Education American Board of Nuclear Medicine
Obstetrics-Gynecology	AMA Council on Medical Education American Board of Obstetrics-Gynecology American College of Obstetrics-Gynecology
Ophthalmology	AMA Council on Medical Education American Board of Ophthalmology
Orthopedic Surgery	AMA Council on Medical Education American Board of Orthopedic Surgery American Academy of Orthopedic Surgery
Otolaryngology	AMA Council on Medical Education American Board of Otolaryngology American College of Surgeons
Pathology	AMA Council on Medical Education American Board of Pathology
Pediatrics	AMA Council on Medical Education American Board of Pediatrics American Academy of Pediatrics
Physical Medicine & Rehabilitation	AMA Council on Medical Education American Board of Physical Medicine & Rehabilitation

RRC	Sponsoring Organization
Plastic Surgery	AMA Council on Medical Education American Board of Plastic Surgery American College of Surgeons
Preventive Medicine	AMA Council on Medical Education American Board of Preventive Medicine
Psychiatry & Neurology	AMA Council on Medical Education American Board of Psychiatry & Neurology
Radiology	AMA Council on Medical Education American Board of Radiology
Surgery	AMA Council on Medical Education American Board of Surgery American College of Surgeons
Thoracic Surgery	AMA Council on Medical Education American College of Surgeons American Board of Thoracic Surgery
Urology	AMA Council on Medical Education American Board of Urology American College of Surgeons

ESSENTIALS OF GRADUATE MEDICAL EDUCATION

PREAMBLE

These Essentials of Graduate Medical Education set forth the requirements that institutions and programs sponsoring graduate medical education must meet in order to be accredited by the Liaison Committee on Graduate Medical Education (LCGME)* They are divided into (I) General Requirements, which delineate institutional responsibilities and broad general principles common to all programs in graduate medical education, and (II) the Special Requirements for each specialty. The Special Requirements detail the content and scope of education and training which must be provided by programs to physicians seeking to qualify for certification in a particular specialty.

Accreditation of Graduate Medical Education

Accreditation of institutions sponsoring graduate medical education is a voluntary service conducted by the Liaison Committee on Graduate Medical Education and the Residency Review Committees to ensure that they and the programs they offer meet acceptable standards of quality. The voluntary specialty certifying boards that are members of the American Board of Medical Specialties require that education and training qualifying individuals to seek certification in their specialties be obtained only in programs accredited by the LCGME. Exceptions to this requirement are occasionally granted by certifying boards on a case-by-case basis.

The Continuum of Medical Education

Undergraduate Education:

The education and training of physicians in the United States begins with their entrance into a school of medicine as candidates for the degree of Doctor of Medicine. The undergraduate phase,

*The address of the LCGME is: Liaison Committee on Graduate Medical Education, Office of the Secretary, 6th Floor, 535 North Dearborn Street, Chicago, Illinois 60610

which leads to the M.D. degree, is accredited by the Liaison Committee on Medical Education (LCME) and is preparatory for graduate medical education as indicated in this statement from the LCME's "Structure and Functions of a Medical School":

> *"The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects."*

During the undergraduate phase, students gain knowledge of the sciences basic to medicine and learn to apply that knowledge to clinical problems. Skills in collecting data are developed by interviewing and examining patients and applying laboratory procedures under the guidance and supervision of the faculty and residents. Students learn to utilize these data to arrive at diagnostic hypotheses and make therapeutic decisions. These basic skills are learned by rotations through a variety of clinical disciplines in both inpatient and outpatient settings. Undergraduate students have limited opportunities to assume personal responsibility for patient care, and do not participate in the care of individual patients for an extended period of time.

Graduate Education:

By the time the M.D. degree is awarded, most graduates have made decisions regarding their further professional development and enter the phase of their education which is termed graduate medical education with the intent to prepare themselves for the practice of medicine in a specialty. For most, this means completing the special educational requirements for certification by a specialty board. A few enter practice before meeting these requirements. Others, after completing the requirements of a primary board, enter into additional training in order to achieve recognition of special competence in a subspecialty.

Physicians who choose to pursue graduate medical education acknowledge their need for education and training beyond the minimum legal standard established by state and territorial laws and regulations, which generally permit physicians to be licensed upon completion of their first year of graduate medical education. The term "resident physicians" has been applied to those in clinical graduate medical education.

In the graduate phase, residents first assume limited, personal responsibility for patient care under the supervision of faculty physicians. The opportunity to learn about the variability of human beings in health and disease, and about their biological, psychological, and social problems is provided through direct and continuing responsibility in caring for many patients. Effective graduate medical education requires that residents gain knowledge, skill, and experience, and a progressive increase in their personal responsibility for patient care in a setting which always provides for systematic supervision by responsible faculty.

Continuing Medical Education:

Postgraduate or continuing medical education is the term applied to the phase of medical education which extends from the completion of formal graduate medical education throughout the professional life of physicians. It is based on a variety of educational strategies ranging from independent study through attendance at formal lectures and participation in seminars to medical audit.

Transition Between Undergraduate and Graduate Medical Education:

The transition from being an undergraduate medical student to the assumption as a resident of an increasing degree of personal responsibility for patient care is a critical period in the professional development of every physician.

This period is made even more critical because most residents are taking their first step toward differentiating into one of the

specialty careers available in the practice of medicine. Throughout the first year of graduate medical education (the G-1 year), special efforts should be made by the teaching staff to determine whether the career aspirations of residents are realistic, and whether they have a sufficient breadth of knowledge and experience to undertake education and training in their chosen field. Career counseling should be provided in order to ensure that residents are guided appropriately.

First year graduate medical (G-1) programs of two types are available to residents at the transition. These are:

Categorical: These G-1 programs are based on the special requirements of a specialty, are principally provided by the teaching staff of a single program, and predominantly provide an educational experience in that specialty. Rotations in other clinical areas may be permitted or expected.

Diversified: These G-1 programs are based on the special requirements of two or more specialties, are provided by the teaching staffs of two or more programs in an institution, and prepare residents to enter at the G-2 level of the specialties sponsoring the diversified program.

I. GENERAL REQUIREMENTS

1. Institutional Responsibility for Graduate Medical Education

The principal institutions which provide programs in graduate medical education are teaching hospitals and the medical schools with which they may be affiliated. Health-related organizations and agencies may also participate. Whatever the institutional form, the LCGME requires that there be a firm institution-wide commitment to medical education. The following policy statement was approved by the sponsoring professional organizations of the CCME in 1974.

> *"Institutions, organizations and agencies offering programs in graduate medical education must assume responsibility for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.*
>
> *While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must insure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.*
>
> *The governing boards, the administration, and the teaching staffs must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training.*

Facilities and teaching staff shall be appropriate and sufficient for effective accomplishment of the educational mission of each program. If outside facilities or staff are needed to fulfill program needs, the primary sponsor must maintain full responsibility for the quality of education provided."

Graduate medical education is conducted in institutional settings wherein there are invariably several missions. Providing clinical services of the highest quality must be the principal mission of hospitals and clinics sponsoring programs in graduate medical education. The range and scope of primary and ancillary clinical services must be sufficient to provide educational opportunities consistent with modern medical practice. All of those who use institutions and their resources for graduate medical education are expected to collaborate to ensure that all institutional missions are achieved, particularly excellence in patient care.

Institutions sponsoring programs in graduate medical education must undertake the educational mission fully aware that the education of resident physicians requires the provision of patient care by residents. However, a commitment to education must supercede any intent to expedite the provision of services. Patient care can be provided in the absence of an educational program, but a sound educational program necessitates involving residents in progressive levels of personal responsibility for patient care under supervision.

Accreditation of graduate medical education programs requires that institutions meet the standards set forth in these general requirements and that each specialty program meet the standards set forth in the special requirements for that specialty*

Recognizing that the requirements for establishing institutional responsibility will necessitate considerable modification of present policies and procedures in most institutions, the LCGME intends to develop a phased program of implementation which will provide sufficient time to adapt to these new requirements.

1.1 The LCGME requires that institutions sponsoring programs in graduate medical education provide documentary evidence of a commitment to medical education by:

a) the institutional governing board
b) the institutional administration
c) the teaching staff
d) the organized medical staff

This evidence shall consist of:

1.1.1 A written statement setting forth the purposes for which the institution sponsors graduate medical education. There must be tangible evidence of agreement to this statement by the teaching staff, the organized medical staff, and the administration. The statement must be agreed to and approved by the governing board.

1.1.2 A detailed plan which sets forth how institutional resources are organized and distributed for educational purposes. Such resources include teaching staff, patients, physical facilities and financial support. There must be clear evidence that the plan is agreed to by the administration, program directors, and the organized medical staff, and approved by the governing board. Those responsible for administration of the plan must be identified by name and title in the institution's table of organization.

1.1.3 An operational system, based on institutional policies, established and implemented for graduate medical education programs deemed appropriate for the institution to provide for:

a) the appointment of teaching staff;
b) the selection of residents
c) the apportionment of residents among programs;
d) the evaluation, promotion, and graduation of residents;
e) the development and publication of personnel policies applicable to residents;
f) the termination of residents whose performance is unsatisfactory;
g) the assurance of due process for residents and teaching staff.

These policies must be agreed to by the administration and teaching staff, incorporated in a manual of policies and procedures, and reviewed and approved by the governing board. Further, there must be clear evidence of adherence to these policies and procedures.

1.1.4 An operational system for periodic internal analysis of each sponsored program by the teaching staff, residents, and administration. Such analyses shall include critical appraisal of:

a) the goals and objectives of each program;
b) the instructional plan formulated to achieve these goals;
c) the effectiveness of each program in meeting its goals, including the performance of enrolled residents on examinations.

There must be clear evidence that analyses are effective, and that mechanisms exist to correct identified deficiencies.

Institutions sponsoring more than one program should provide administrative mechanisms for the coordination of the activities of the teaching staffs of all of the programs in the institution.

Documentation of items 1.1.1 through 1.1.4 must be maintained within the institution in some central place ready for periodic review by the LCGME and the RRCs through assigned site visitors. Evidence of failure by a program to comply with established and approved institutional policies will jeopardize the accreditation of that program. Evidence of institutional failure to implement its established policies will jeopardize the accreditation status of all programs.

When significant modifications in institutional policies, programs, or teaching staff occur between LCGME accreditation reviews, institutions must report the nature and magnitude of such changes to the LCGME.

1.2 Interinstitutional agreements: When the resources of two or more institutions are utilized for the conduct of one or more programs, each participating institution must demonstrate a commitment to graduate medical education and will be required to submit the evidence set forth in 1.1.1 through 1.1.4

The following items must be covered in interinstitutional agreements. Documentary evidence of agreements, approved by institutional

governing boards must be available for inspection by assigned site visitors.

1.2.1 Items of agreement:

a) Designation of program director: A single director for each program must be designated. The scope of the director's authority to direct and coordinate the program's activities must be clearly set forth in a written statement.

b) Teaching staff: The teaching staff responsible for providing the educational program and supervising the residents must be designated.

c) Educational contribution: The expected educational experiences to be provided by each institution to each program must be delineated.

d) Assignment of residents: The period of assignment of residents to the segment of a program provided by each institution and any priority of assignment must be set forth.

e) Financial commitment: Each institution's financial commitment to the direct support of each program must be specifically identified. Such commitment should include residents' stipends, reimbursement of teaching staff, and provision of monies for books, teaching equipment, etc. Agreements should provide for an equitable distribution of the financial support for all sponsored programs among the participating institutions.

f) Other: Fringe benefits and special privileges for residents should be as consistent as possible from institution to institution.

1.2.2 When several institutions participate in sponsoring multiple programs, administrative mechanisms should be developed to coordinate the overall educational mission and facilitate the accomplishment of the policies and procedures set forth in subsections 1.1 and 1.2.

1.3 Facilities and Resources: Institutional facilities and resources must be adequate to provide the educational experiences and opportunities set forth in the special requirements for each sponsored program. These include, but are not limited to, an adequate library providing access to standard reference texts and current journals, sufficient space for instructional exercises, adequate facilities for residents to carry out their patient care and personal educational responsibilities, and a patient record system which facilitates both good patient care and education.

1.4 Hospital Accreditation: Hospitals sponsoring or participating in programs of graduate medical education are expected to seek and attain accreditation by the Joint Commission on Accreditation of Hospitals. If a hospital is not so accredited, the reasons why accreditation was not sought or was denied must be explained and justified in the materials submitted for review by the RRCs and the LCGME.

2. The Teaching Staff

The individuals who have responsibility for the conduct of graduate medical education programs must be specifically identified. These should include physicians, basic scientists, and other health professionals.

2.1.1 The program director: The director should be recognized as highly skilled in the appropriate medical field, with a clear commitment to education and the advancement of knowledge. The director should have an institutional position which provides the authority and time needed to fulfill administrative and teaching responsibilities, and to achieve the educational goals of the program.

2.1.2 Teaching staff: The teaching staff should consist of members of the medical staff with institutional positions and those who voluntarily participate in the educational programs. They should be selected for their abilities to con-

tribute to the educational goals and objectives of the programs and should have sufficient time to discharge their responsibilities.

2.1.3 Other health professionals: Graduate medical education requires that the activities of all involved health professionals be integrated in the care of patients. The medical teaching staff with the primary responsibility for educational programs should involve other health professionals in its programs.

2.2 Relationships between medical staff and teaching staff: In some institutions the organized medical staff and the teaching staff are differentiated. Where this is the case, the institutional educational plan (1.1.2) must clearly delineate the agreements reached regarding the utilization of institutional resources for education. This must include agreement relating to the contact of residents and teaching staff with the patients of members of the organized medical staff not involved in the teaching program.

3. Resident Physicians

Resident physicians with the following qualifications are eligible to enroll in graduate medical education programs accredited by the LCGME.

3.1 Unrestricted eligibility: Unrestricted eligibility is accorded to those with the following qualifications:

3.1.1 Recipients of the M.D. degree granted by institutions in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME).

3.1.2 Recipients of the D.O. degree granted by institutions in the U.S. accredited by the American Osteopathic Association, unless prohibited by Special Requirements.

3.1.3 Recipients of the M.D. degree (or its equivalent) from foreign medical schools not accredited by the LCME who meet the following additional qualifications:

a) Have been granted the privilege to practice medicine in the country of the institution granting the degree, have passed an examination designated as acceptable by the LCGME, and have had their credentials validated by an organization or agency acceptable to the LCGME; or,

b) Have a full and unrestricted license to practice medicine in a U.S. jurisdiction providing such licensure.

3.1.4 In the case of U.S. citizens:

a) Have successfully completed the licensure examination in a jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted after successful completion of a specified period of graduate medical education; or,

b) Have completed in an accredited U.S. college or university undergraduate premedical education of acceptable quality, have successfully completed all of the formal educational requirements of a foreign medical school, but have not been granted the privilege to practice medicine by the country in which the medical school is located by reason of not having completed a period of required service, and have passed an examination designated as acceptable by the LCGME.

3.2 Restricted eligibility: Restricted eligibility for foreign nationals to enroll in LCGME programs is accorded under the following circumstances:

a) When a U.S. medical school and one or more of its affiliated hospitals have a documented bilateral agreement, approved by an agency recognized for that purpose by the LCGME, with an official agency or recognized institution in the resident's country of origin to provide an educational program designed to prepare the resident to make specific contributions in the health field upon return to the country in which the sponsoring agency or institution is located; and,

b) The resident has been accorded the privilege to practice medicine in the country wherein the agency or institution making the agreement referred to in (a) is located; and,

c) The resident has passed examinations designated as acceptable by the LCGME for determination of professional preparedness and fluency in the English language; and,

d) The resident has made a formal commitment to return to the country in which the sponsoring agency or institution is located; and,

e) The credentials of the resident and the existence of a suitable agreement have been validated by an organization or agency acceptable to the LCGME.

Restricted eligibility shall be limited to the time necessary to complete the program agreed to by the parties as referenced in (a), without regard as to whether such agreement fulfills the requirements for certification by a specialty board.

3.3 The enrollment of non-eligibles: The enrollment of non-eligible residents may be cause for withdrawal of accreditation by the LCGME.

3.4 Selection and recruitment: It is expected that institutions and their sponsored programs will select residents with due consideration for their preparedness to enter into the graduate medical education programs that they have selected. Criteria for selection of residents should include personal characteristics as well as academic credentials.

In selecting G-1 residents, institutions are encouraged to participate in The National Intern and Resident Matching Program (NIRMP)*. Participating institutions should ensure that all of their sponsored programs adhere to the principles and policies established by NIRMP.

The NIRMP is a voluntary agency sponsored by: American Hospital Association, American Medical Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Student Association, and American Board of Medical Specialties.

The recruitment of residents by institutions and programs is premature when it causes students to make career decisions before they or their medical schools have been able to evaluate their interest in, or fitness for, a particular specialty; such early recruitment is strongly discouraged.

4. Relationships Between Institutions and Residents

Resident physicians are expected to nave an unreserved commitment to the professional responsibilities expected of all physicians by society. Institutional policies relative to residents' responsibilities must be made available to applicants prior to their making a decision to seek enrollment in a sponsored program.

4.1 Residents' responsibilities: Being an enrolled resident physician in an accredited program of graduate medical education requires the assumption of responsibility for:

a) Participation in the institutional programs and activities involving the medical staff and adherence to established practices and procedures;

b) The provision of medical services, under supervision, to the patients who seek such services from the institution; and,

c) Participation in the formal instructional program presented by the teaching staff; and,

d) The supervision and instruction of medical students and more junior resident physicians; and,

e) The development of a personal program of self-study and professional growth.

4.2 Agreements with enrolled residents: There should be an individual written agreement between the institution and each resident enrolled in its sponsored program. Parties to this agreement should be the program director, the individual designated as having institutional authority, and the resident. The agreement should encompass the following:

4.2.1 Stipend: If a stipend is provided by or administratively managed by the institution, the annual stipend level and other benefits should be stated. The purpose for which the stipend is provided should be stated.

4.2.2 Programmatic requirements: The responsibilities of the resident in the educational program, including independent study, patient care responsibilities, on-call responsibilities, teaching and supervisory responsibilities, and periods of assignment to participating institutions should be detailed.

4.2.3 Evaluation and promotion: The institutional policies and procedures for evaluation and promotion of residents should be clearly stated and the rights of residents to due process in the review and determination of the adequacy of their performance should be delineated.

4.2.4 Other elements: The agreement should clearly state institutional policies for:

a) vacation, professional leave, and sick leave;
b) practice privileges outside the educational program;
c) malpractice coverage.

4.2.5 Individualized programs: Individualized educational plans, such as a reduced schedule or educational opportunities tailored to meet a resident's career development aspirations, must be specified. General agreements arrived at through any collective negotiation between residents and the institution must not inhibit the development of programs to meet the individual needs of residents.

4.3 Due Process: Institutions sponsoring graduate medical education programs must have a written procedure which provides an opportunity for residents to appeal actions by the staff or administration when such actions are perceived to threaten the resident's intended career development. This procedure must be agreed to by the teaching staff and administration and be reviewed and approved by the governing board.

4.4 Reporting requirements: Institutions sponsoring accredited programs in graduate medical education must report annually the names of individuals enrolled in their programs, the institutions from which they received their M.D. degree (or equivalent), the program in which they are currently enrolled, and the program in which they were enrolled for the previous year; in addition, institutions must report those individuals successfully completing their sponsored programs. These reports shall be supplied to the LCGME and to agencies designated by the LCGME as having responsibility for the recording of credit and the collection and analysis of data on physician manpower and development.

5. *Relationships Between Teaching Staff and Residents*

Medical education requires a collegial atmosphere wherein all who are involved have the common goals of serving the needs of the patients who seek care and advancing the quality of medical practice. The professional development of residents as they advance through the continuum of medical education requires that there be a relationship of mutual respect and understanding between and among them, their teachers, and those whom they themselves teach. Building such a relationship and maintaining such an atmosphere is preeminently the responsibility of the teaching staff. Institutional administrators and governing boards must support these policies and provide the resources needed to promote a harmonious educational environment.

5.1 Supervision: Graduate medical education must be based upon the assignment to residents of increasing levels of personal responsibility for patient care in accordance with their experience and growing competence. On the other hand, there must be continuous supervision of all residents at all levels at all times. The plan for supervision must provide for regular and systematic review of the actions and decisions made by residents through clinical rounds and tutorial sessions. Review of performance and progress must be provided to residents at frequent intervals. Residents who are insecure about their abilities to assume or discharge responsibilities

to patients have a professional obligation to request additional supervisory assistance at any time, and members of the teaching staff are obligated to respond promptly to such requests. The development of a supervisory relationship embodying mutual respect and trust is imperative. Residents who consistently fail to seek assistance when they are faced with problems beyond their abilities must demonstrate that they can respond to corrective action or, if need be, must be terminated from their program.

5.2 Teaching and learning: An environment wherein both the teaching staff and the residents are seeking to improve their knowledge and skills is essential. Senior residents are expected to assume responsibility for teaching junior residents and medical students. The teaching staff is expected to organize formal teaching sessions tailored to meet the special requirements of their sponsored programs. Participation in these sessions by teaching staff from other clinical specialties and by teaching staff from the basic science disciplines is encouraged.

5.3 Formative evaluation: Formative or "in-training" evaluation is encouraged. Evaluation instruments may be prepared by the teaching staff, or the "in-training" examinations developed by certifying boards or specialty societies may be used.

5.4 Evaluation conferences: Periodically, and at least annually, members of the teaching staff must organize conferences to evaluate the performance of each enrolled resident. Participants in these evaluation sessions should include the program's teaching staff, residents with supervisory responsibility for more junior residents, and teaching staff from other programs with which the residents interact. A summary of the evaluation of each resident's performance must be discussed with the resident.

Evaluation summaries must be kept on file by program directors and by the institutional administration. The summaries must be available for inspection by the LCGME through its assigned site visitors and be accessible to the resident.