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P R O C E E D I N G S

MR. : Tell us what you think happened in your session, Fran.

MR. Garong : Our group was well balanced in terms of basic and clinical representation -- we had six basic science people, 11 clinicians, and in addition to this, we had Harold Jervy from the Federation with us, and Bob Chase, Roy Swann and Brice Templeton and Dax Taylor from the National Board of Medical Examiners sitting in with us -- so we had excellent opportunity for review and answers to various questions that were raised.

We reviewed the sample CQE, as everybody else did, for awhile before we actually started our discussion. Bob Chase tells me that this CQE sample that we saw is a biopsy, but after some debate, we decided that the biopsy should be representative of the whole specemen if not serial sections, and consequently, we reviewed the CQE examination on the idea that it was representative.

There was immediate concern expressed when discussions started about the question of basic science representation and material on this examination, and the general consensus of all Council of Academic Society representatives in our group, at least, was the basic science material in the examination was not adequate in either quantity or quality.

The quantity question is more or less self evident, although it is relevant that the National Board people agree that the percentage of basic science material in the final examination is still an unsettled question.

In addition to this, by defects as far as quality is concerned, the members of the group were worried about several things -- they were worried about the fact that all the basic science material seen in the examination as we were able to scan it, seemed to be relatively applied and very much patient related, rather than barter examination of basic science material.

And, in addition to this, there was concern that the examination gave very little opportunity to include testing of new material, material which is close to the cutting edge of advances in the basic science fields.

This is of some importance, because certainly, with the explosion of information and the growth of knowledge in the basic science area, the material which doesn't have immediate clinical relevance today is going to be practiced very shortly in the future -- and there was a general consensus that there should be some way to get at least some testing of this type of material on the examinations.

There was some debate about whether or not this criticism applied equally well to the present part one; in other words, whether it was unique to CQE. Some felt it

was and some felt it wasn't. But at least there was agreement that as far as our CQE biopsy is concerned, this criticism is something which concerned us.

There was, in addition to this, a general consensus by all the Council of Academic Society representatives present that it was beneficial and important to continue a mechanism by which basic sciences could be tested at the end of the second year; in other words, a continuation of part one examination, or something equivalent to it.

And we agreed that then it would be wise to reinforce the basic science material, as presently is planned, on the CQE and probably on Flex Two, as well.

It was within this context that we followed up Dr. Holden's suggestion and discussed the proposal, which is, as I understand it, a recommendation from the Executive Committee of the National Board of Medical Examiners to the full board, and that proposal is that the National Board continue certification, consisting of the National Board of Medical Examination, part one examination, Flex One and Flex Two, to be administered to graduates of accredited United States and Canadian medical schools who have at least one year of accredited, post doctoral training.

This view was endorsed unanimously by the Council of Academic Society members in attendance as a worthwhile plan and something to which we could strongly support.

There was considerable debate about the timing of the Flex One and CQE examination, and no definite conclusion was reached. The suggested timings ranged in our discussion group from early in the fourth year to February of the fourth year of medical school, to a proposal that it be given in June, after graduation, in May and early June, from medical school.

This June timing, however, ran in to some debate and criticism because it was argued that if examination occurred at that time after someone had been accepted to a post doctoral program, and then if the individual failed, this would create a problem which would be of considerable magnitude; what to do with the flunkees, if you will, indeed, is still I think an unsettled and possibly, rather troublesome problem.

But the consensus of our group seemed to be that this is probably better a medical school problem, and that therefore, having the examination occur before graduation from medical school was the appropriate route to go. The timing still needs additional work and additional analysis, obviously, before any final conclusions can be reached.

We were also very interested in developments in relation to the Flex Two examination, and appreciate the fact that there are still many unanswered questions about this. There was debate about the timing of Flex Two, there

was concern about it from two points of view because, if on the one hand it is given at the end of the first year of post doctoral training, it will come very close after Flex One, and give relatively little time between the two; yet, if it is given after this, it will create a problem it seems to us, as far as those 15 to 20 states which now permit individuals to practice after they have received the MD degree, and it will in effect, require specialization of all medical, specialized training of all medical graduates.

On the other hand, if one waits for two, or more years, specialty training nowadays becomes more and more specialized and more and more arcane, so the problem arises -- how can such an exam as Flex Two be comprehensive and cover everything if one waits for a number of years into post graduate training?

For example, can one expect a psychiatrist to pass the same examination as a pathologist who in turn will pass the same examination? After considerable post doctoral training now, mind you, as a solastic surgeon or a plastic surgeon.

Some felt it was unrealistic to ask the trainees to do this, but others argued and the point is of course, also well taken that anybody who practices on the public should be able to pass this examination on fundamental knowledge -- this is the Flex Two examination.

of our group, we'd like to push the message that we are concerned about basic science material both in terms of quantity and quality on the proposed CQE examination, that we felt that there should be a continuation of part one of the National Boards, and that we thought it was a good idea to have this be a part of -- a sequence of part one, Flex One and Flex Two examinations. We're concerned and worried about the questions of timing of the Flex One examination, and we look forward with interest to future development of proposals about the content and the timing of the Flex Two examination.

Dr. Freedman: Thank you.

I realize, as these summaries go on, that we will be reprising each other, and we will be calling on you from the floor -- I think that will be the easiest thing, so we have discussion. So if we hear the four reports, then maybe we can have queries of either the different discussion groups or just take the topics and move ahead with them.

If Joe Johnson will report on his group?

Dr. JOHNSON: I think it is very obvious, as Dan said, that there will be some overlap of topics and concerns, but I think it is quite possible that somewhat different perspectives arose in the different groups, and therefore, it might be useful for me to just quickly cover the major ones, even though they may duplicate the ones you've already ... (CUT)

We also, [redacted] had Bill Daeschner and Bryant Galusha, Jack Myers in our group, and Dr. Schumacher and Jones from the staff, and we had Bill Holden, also, who was in for part of the discussion. So it was, I think, very useful to get some authoritative information and some facts which I believe did help clarify and at least resolve some of the anxieties.

I believe we had a very positive group in terms of understanding many of the issues, and better communication on what the specifics are.

We did spend about the first 30 to 40 minutes of the time reviewing the examination test samples which were provided to all of us, and then began the discussion about those items in particular. I would say that several concerns did surface fairly early about the question, the sample questions. It was pointed out that many of these items look very familiar, that for at least a couple of the basic disciplines, the concern was expressed that relatively little specific coverage of that area seemed evident in the test booklet.

Representatives from the National Board pointed out that there had not been time to develop enough new questions in time to incorporate them into this prototype, and for example, that we did not -- in that booklet of several hundred questions, there were perhaps only 10 or 15 new

questions of the specially designed integrative type that Dr. Swann described yesterday.

I guess we could say that there were only 10 or 15 "Swannoid" questions, or not a Swanola, I don't believe, but at least -- in any event ...

So, for that reason, we perhaps did not have a totally representative sample of what the exam will be like presumably in the future.

The question arose, then, what was the field test testing, since most of the items here were derived from the pool, the library, and it was pointed out that the test was really looking at the different responses of brand new, first day medical students, versus the second, third year interface, versus senior medical students, and the conclusions then, relate to the evolution of the responses -- correct responses -- by these differing groups. But really did not, has not thoroughly field tested any of the new, or very much of the new material. That will be done, we were assured, however, in the future.

There are no decisions yet about the specific composition of the CQE in terms of different disciplinary -- how much anatomy, how much biochemistry, etc., should be on there, and in fact, I think your groups, at least, our group received a questionnaire from the Board staff to get input from the CAS members about ideal distribution of

representation of the different disciplines.

A number of issues were then placed upon the table, and I think we, at least, erred, and we had a number of concerns about the process of developing the CQE, and about the philosophy of the change.

And, quickly, just to review a couple of those, some of which you've already heard mentioned and maybe one or two of which may be new -- there certainly was also in our group a concern about the impact of Flex One on the senior year. If -- and the same questions about timing arose -- what do we do if we have people who, for example, fail Flex One, but don't know that until after they've already been matched in a program somewhere?

One response was that it was anticipated that there should be a much lower failure rate of Flex One than there has been of part one, for example, or part two, and therefore, we should perhaps not have so large a quantitative problem -- but nevertheless, I think the distinct concern expressed about the issue of the timing and the interaction.

It was pointed out that the true interface perhaps is not on February first, in the senior year, but in June -- after the graduate gets his degree. And one suggestion from the group was that it might be more rational to give this exam in June after the MB degree, and to totally dislink, if you will, Flex One from the educational process.

Then there is the issue of the timing --it was pointed out that the Flex One probably would have no real relevance for selection of house staff, but it has a lot of interest to individual medical students in terms of where they're going to locate. More medical students are married now, they would not be happy to wait until May or June to know where they're going to have to move to on the first of July. Wives need to work, housing needs to be obtained, and many other issues.

The impact of Flex Two, which is obviously very early on, also was raised --the question of what would be the impact on the specially training programs, depending on when the timing of this part would be given; potential conflicts with in service training examinations, which in many areas are given on a regular basis --and other concerns of this type certainly were surfaced.

There was a concern to move on to our major common theme, I think -- I am sure -- for all groups, was the concern about the impact of the new proposal on the basic sciences in general. It was recognized that the examinations do drive curricula, whether we like it or not, and that in fact, what will be the impact if part one is no longer required, what will be the impact on basic sciences, the identity of basic sciences, and the whole basic science curriculum in the medical school and so forth.

Now, it was pointed out that of course it is now proposed that part one be retained at least as an option for medical faculties to use. On the other hand, if it is not an alternate pathway to licensure, will it in fact be taken by many students? There was difference of opinion about this, I think. It depends on, in part, and perhaps a major part, upon decisions of medical schools as to whether they will in fact require part one under this new arrangement.

And an interesting suggestion surfaced, which I will get back to in a moment, about how one way of preserving part one with teeth, which may or may not work. And I'll get back to that in just a second.

Other concerns arose -- how is Flex One different from the current arrangements? Obviously, the philosophy is that it should be more integrative of basic and clinical sciences; many felt that this would be very fine for an interface type examination, if in fact we also preserved part one, that the philosophy of an integrative exam seemed to be popular, but there was the concern that that alone would not totally represent the basic science concerns.

If part one is not retained and somehow required or made to be an important, integral part of the system, the danger of having medical schools depend upon the licensing boards to maintain academic rigor in the medical schools was pointed out as a major concern.

Will the Board give the CQE or make it available to foreign medical graduates? Presumably not, as we understood it.

Would -- it was suggested from several sources, including the Board and others in the group -- that it would be essential that foreign medical graduates, including U.S. foreign medical graduates, have an additional measure of their clinical competence, some sort of either hands on evaluation process, as a requisite to entrance to CQE. It was felt, I believe, by many that there needs to be some additional measure that simply passing a Flex One, Flex Two sequence does not, as currently described, does not satisfy us that these foreign graduates will in fact have had the important skills and bedside teaching, etc., that we think is essential.

So, in some form, a different, separate, additional hurdle, standard should somehow be introduced.

Now, one of our members pointed out that he had heard about solutions all day long, but he was concerned about what was the problem? And in fact, what's wrong with what we're doing now? And, I think the answers were interesting to this. It was -- I believe that the Federation believes firmly that we need a better exam, a more difficult exam, and that this exam, for example, might help in the problem of how to deal with the foreign medical graduates.

It was also pointed out that the lack of a single route of licensure leads, at the moment, to big problems with, legal problems, litiginous problems with -- for many of the state boards, there are problems about how state boards, there is a strong feeling, I gather, among the states that there is a need for a single route to licensure.

On the other hand, I think there is still a significant feeling that it would be desirable to retain some sort of optional alternative pathway until at least we get a better handle on how the Flex One, Flex Two sequence will work.

The -- I think the sum, in summary, our meeting led to considerably -- to a lot of education in terms of what the proposals are and that there was, I think, also expressed a much greater understanding, at least on the part of some of us, about what the problems faced by the Federation are, and what the attempts are and the reasons for these changes on the part of the National Board.

I would say that the major issues, then, that we were concerned with again related to the ultimate impact on the basic sciences. The concern about the loss or decrease in the identity and role of the basic sciences in the curriculum. Some concern about the process, and still, I think, a lingering uncertainty about exactly how the basic science faculties will be represented in the process, although

again, some reassurance in terms of the technique proposed by Dr. Swann, and the description of how the questions are being written now.

Some concerns about the interface and about the single route, as I've already expressed. I do believe that we wound up with considerable understanding and that I would say that it was probably the consensus of the CAS members there that if in one way or another we could retain the part one as an important, as an essential link in the chain, that we would probably be much more comfortable. It was suggested that one way to do this would be at the medical school level, by encouraging the faculties to require part one in some way -- or conceivably, through the LCME.

If, for example, the LCME would require or would -- that there would be some sort of comprehensive examination; for example, part one -- of the basic sciences, this might give the faculties and the medical schools amunition with which to accomplish this.

This is an interesting suggestion, I think; it may or may not be practical, but one which ought to be considered. Thank you.

Dr. Freedman: Thank you. I think you made a very good point, that every group somehow or another emphasized things just a bit differently, and therefore, we'll hear from Bob Hill's group.

DR. HILL: Our group -- well, let me begin by saying I don't know how Fran Gilmong and Joe Johnson knew what went on at our meeting -- it sounds like they gave our report for our committee. So I'll just emphasize a few points that I think are important that emerged from our meeting. We were fortunate enough to have Edith Levitt and John Morton and Bob Barker representing the National Board -- and they were very helpful in getting us on track sometimes with our evaluation of the CQE exam that was given to us.

Now, what about the CQE sample questions? Well, I think the opinion was that they were generally well balanced, they seemed adequate. To the opposite extreme, that they were utterly awful. And I think that the criticism of the questions was in part, due to the frustration that many of them were not good, basic science questions; they were presented in a context of a disease, which seemed somewhat contrived, and that there was a need for more imaginative, bare, simple, basic science questions for themselves.

The clinical science questions were considered also for quality, and I didn't hear that much criticism about them as I did the basic science question -- maybe that's because of my own interest.

Neverheless, there was some criticism from some quarters that perhaps they weren't as good as they should be, and that there were other Board exams around where they were better. But that was discussed, and the general conclusion was

the National Board exam quality was about as good as many of the other boards.

But I think there was an interest in and a support of the Board attempting to devise better questions all around.

So, so much then for the quality of the product. The quantity, of course, was just like the other committees. Basic sciences were thought to be required and emphasized in any future examination for board certification or licensure.

The timing of the examination was discussed, and we -- like the others -- felt that probably, it is the responsibility of the medical schools, not the boards, to deal with the failures of the students to fail the examination.

We had no imaginative timing to recommend how to accommodate this problem or how to adjust to it.

We also had discussion about, from several standpoints, about how the Board examinations drive the educational process and some vise versa. Many people felt that any examination that evaluates academic achievement is a good examination for determining licensure or certification -- and we thought that it was somewhat artificial to uncouple and emphasize you can't evaluate educational process with these exams, the same exams that you use for licensure.

I think there was discussion about foreign medical graduates and what to do with the problem -- can the examinations

do anything about that? And, frankly, I think we shed no light on the issue. There were many ... everyone dispaired about the problem; we know it's not going away, but we don't know what to do about it.

Now, at the end of the session, there was unanimous support for the concept that, well, for the concept that the National Boards retain their certification procedures. There was, I believe, understanding that the state boards certainly have the responsibility for licensure, and that is their responsibility -- but I think there was a feeling that the Federation should not urge a single pathway, but allow for multiple pathways, or certainly allow for the one that was proposed and presented by Bill Holden yesterday morning; that is, we could support the concept that there be a part one, followed by Flex One, Flex Two.

Of course, in supporting that concept, I think the committee also said -- or our discussion group said -- that we would like to see what the details are. For example, if part one remains the first step in certification, and part two would become CQE or Flex One, would CQE and Flex One -- or Flex One (I'll treat them equivalently) -- would they change in their basic science content? That is, if those individuals who are licensed only through the CQE or the Flex One, Flex Two pathway, do not have much basic science, that's a very poor pathway.

So, there was endorsement of this concept, but we want to see the details. What will be the system, once developed?

There was discussion -- why would the certification by the National Boards be useful if there was an easier pathway; that is, just going through Flex One and Flex Two in certain states. And people felt that there was enough, there were enough reasons, incentives, for students to go the NBME certification pathway for licensure. For example, many medical schools still require part one now; they may do so in the future, in increasing numbers.

So if a student is passed part one, they could go right through the CQE Flex Two pathway. Indeed, many -- it was also said and pointed out that many residency programs want to know what part one scores were -- so part one would remain an important exam for many students. Students know that if they have taken the NBME pathway, they would be better prepared to get possibly accepted in to the best residency programs.

So we felt that there were enough incentives to keep this pathway open and viable --and I guess there was some comment that it would probably be imprudent of the Federation to attempt to not allow certification through NBME to be equivalent to licensure, because many expressed quite bluntly the fact that the academic community is relied upon

to create the examination questions that are used ultimately on the CQE Flex Two system -- and many people felt that if the state boards would simply dominate the system and not allow the NBME pathway for certification and licensure to exist -- that the academics would get quite disinterested and creating questions.

Whether that's a real thing or not, or whether it's a threat, I don't know -- but that kind of opinion was expressed, and I think should be brought out here.

So, I think that then is a summary, as I see it, of our kinds of discussions -- I think they were good, profitable and I think they weremade in good spirit, that we recognize the board is trying to create innovative questions. We recognize that any examination is imperfect, and the criticism of simply urging the board to get on and get a real prototype of the CQE, let us evaluate it, and I think things might be better in the future in our discussions if we could see this prototype exam complete, rather than sample questions.

DR. FREEDMAN: Thank you, Bob. We'll wind up with T.R. Johns and his group.

DR. JOHNS: Danny, and ladies and gentlemen -- Danny, I thank you for letting me prevail upon you to speak last. The real reason is that I knew that Joe Johnson and Bob Hill were going to be speaking, and I wanted to be sure to follow them.

Just as an aside -- on Wednesday evening, Joe Johnson's Lake Forest basketball team beat my Virginia basketball team. Yesterday, in our first face to face confrontation with Bob Hill, from Duke there, Joe insisted on a very detailed dissection of that game on Wednesday evening. I felt that probably he would get back to that subject again this morning, and I wanted to be sure to have the last word.

But, Joe, I still haven't gotten over it.

Dr Freedman: We're not a basket case!

Dr Johns: We're not a basket case yet -- no. We had an excellent group yesterday, and obviously, we must give credit to AAMC staff for permitting that and giving us a good distribution. We had members of the Federation, from the NBME Steering Committee and staff, a mamber of the External Examination Review Committee of the AAMC, and AAMC staff in the person of Jim Urdman, and members of CAS -- and by chance, I think, all of the MD's in our group had academic positions, regardless of the constituency or the committee they were representing.

We spent, including reading the examination, sample examination of CQE and discussion -- we spent 1½ hours on that.

Some of the opinions expressed, and with the exceptions that I will point out, it was remarkable how I think we were reaching general agreement, regardless of

where we are coming from, we had considerable general agreement.

We were warned by NBME staff that this sample examination does not reflect the breadth or the depth of the proposed examination -- it was a stage in evolution.

We understood, and were told by members of the Steering Committee for the CQE that they had developed the matrix, and then there had been a search of the pool of questions for parts one and two, for suitable questions. And it did, as was mentioned before by Joe, I believe -- result in about 15 new Swann type -- or Swannoid, and not Swannoma, Joe -- questions.

There were some special questions developed in regard to patient management and some other aspects.

The examination, then, which has been field tested or is being field tested, is similar to the examination which we have seen. In terms of hours of examination, if the CQE is proposed to be a two day, perhaps 14 hour examination, the material that we saw yesterday would hypothetically represent about one third of the final examination.

Most people, and particularly those from NBME had felt that in order to get the type of questions which Roy Swann emphasized that would relate basic and clinical science well, that it would require 1½ to two years to write enough questions for an examination which would last two days.

The group felt that the questions we were seeing obviously were similar to, but not as difficult, as the part one examinations that many of us are somewhat familiar with.

The opinion was also expressed that they were not as difficult as those in Flex, in regard to basic science.

After some discussion in regard to comparing further CQE with parts one and two, it was stated and seemd to be agreed that CQE was not intended to provide scores, subscores by disciplines, or analysis to compare with part one and two, which could ultimately aid faculty in student evaluation.

We had evidence that the Flex examination had been very effective in dealing with the problem of foreign medical graduates in California. Both members of the Federation and the Steering Committee for CQE wished to apply it to graduates from American medical schools with the estimate that perhaps two percent of that group are not prepared to do post MD year, and the reason was not clear. I'll come back to that later.

We all appreciate that about 85% of our students now take part one and two of the national board. It was certainly pointed out that the nature of the examination, with it perhaps being somewhat less difficult than part one, did not mean that it would always be difficult for someone with foreign medical education; that if they had been

trained in examination methodology, that they might well pass an examination, even though we might otherwise consider their medical education lacking.

We were fortunate that Bill Holden was with us from time to time, and in responding to questions, he indicated that part one will persist, but only if it is cost effective, and the cost is paid by the medical schools. In response to the question, who would take part one, as the other groups indicated, if it were required by faculty, if it were required by a post MD graduate program in regard to determining the quality of applicants -- or, perhaps if the state were to require it.

I'll try to avoid redundancy, except for emphasis. A question was raised in regard to what is the influence of a required examination or a ubiquitous examination on curriculum. We really didn't pursue that very far, but I think that in formal discussions later, I think many of us agree that most of our institutions find it very difficult to resist the influence of a required examination on our curriculum.

The next step in that line of reasoning is what would the faculty input be in regard to a proposed CQE? Bob Hill has pointed out that there may be increasing lack of interest on the part of faculty to write questions, if they feel that they are not welcome, or they are not having

significant input into the design of the examination, or for other reasons.

That's a question that remains up in the air, I think. In regard to the process of CQE, how or who could determine the ultimate characteristics of the examination which is in the process of being developed -- the same question in regard to pass/fail guidelines and so on.

Some of our conclusions, some stated and some very obvious -- there is no question whatsoever that the Federation and its constituencies have the legal responsibility for licensure. That's beyond debate. There probably is, I think as was deveoloped yesterday by Jack Myers and Roy Swann -- there's no question that we can always do better in writing examinations, and we probably should emphasize further the integration of basic and clinical science and patient management questions, whether we're dealing with parts one and two of the national boards or the CQE. And that's probably a direction that needs to be pursued, and it is being pursued.

The questions that were raised by several different people in our group -- what is the need for CQE? I think we failed in our group to answer.

(CUT)

(END OF SIDE ONE)

Dr Johns

: ... political polarization, which we talk about perhaps at home, has not been apparent here at all -- to me.

But I think that at some point we should discuss it. For a long time, there has been sort of a good humored lack of complete understanding or trust on the part of practitioners of medical faculty, and vise versa, and it's sort of a given, and I think it's not been a very serious thing.

I do believe, depending on whatever facet you choose to observe this interface, that there is increasing polarization, largely political, and I think in regard to this sort of situation -- is there a need for evaluation at the interface, I wonder -- and this is a hypothetical question, I guess -- but I wonder whether there really isn't a question in the minds of people who are primarily involved in the practice of medicine, whether a medical faculty is genuinely interested in, or really qualified to rvaluate a medical student in regard to his ability to enter into practice. If you can separate that from his academic qualifications.

I think it's an issue -- it may even be unconcious on the part of some of us -- but I think there is an area there that perhaps should be discussed at some point.

Danny, thank you.

Dr. Freedman T.R.

MR. : Thank you, . That's an interesting observation. I wonder if we could have some comment from any of the discussants -- you can't be all discussed out yet. And I would say that we are recording this session so that we can send these minutes to AAMC Committee on External Exams, so that they can get a good sense of what faculties feel and what transpired here.

Any comments or questions? Please. If we can have your name for the tape, also.

Dr Rabin Rabin

MR. : David from the Association of Teachers of Preventive Medicine. This comment is not on this last remark, which I think incidentally was a very interesting and provocative one -- I think basically, the question as to whether successful practicing physicians might not have a very important perspective in terms of the nature of this examination, in regard to what is essential for the bottom line of this examination, for successful practice -- is a very important thought relative to the particular perspectives that those of us in academic medicine bring to the question of practice.

However, my major comment has to do with, as I would see it, a major fault in the, or shortcoming, in the reasoning process by which we are approaching the development of this examination.

Most physicians coming through school will fall into

the model, which is being tested in this examination, and understanding of the basic sciences as they relate to the clinical situation that's the diagnosis and therapy of disease.

A small, but very important, proportion of physicians do not fall within that model in terms of their practice perspective. Those physicians are physicians whose basic constituency and perspective is that of the needs of a population.

Those physicians are represented in part by the couple percent of physicians who specifically go on in to administrative positions in local, state and federal health and the armed forces -- but they also increasingly are represented by a group of physicians from many of our specialties that go on in to fields such as environmental and occupational health -- fields which are now acknowledged and recognized rather dramatically by the Geminac Report in terms of being in very short supply, fields which are very rapidly increasing the number of physicians within that.

Mental health -- community mental health -- is another area which demands the concerns of a number of physician and all of us -- interestingly -- in this room, relate now to our particular specialty societies from the point of view of how that particular specialty area relates to the needs of the nation, and not, if we are successful, only to the needs of ourselves within our constituencies in a given school

or a given profession.

While there are a number of specialty task forces or tas forces that are set up to look at particular perspectives that are lacking within the current examination, and apparently in the recent past, ones that were set up in regard to the area of legal medicine, and behavioral sciences, which I think are very important areas. But I think they, in a sense, are vertical -- being concerned with the content of existing kinds of questions.

In contrast, the importance or significance of having physicians going out to practice in society, having an appreciation for the fact that they have an important community and an important population oriented role, is a different perspective than currently represented by the task force -- and I feel it very important that that kind of perspective ought to be expressed, articulated, and come back to be considered within the context of the nature of the examination which is going to be provided in Flex One and Two.

Dr Freedman
MR. : Thank you. Please?

Dr
MR. PAULEY: My name is John Pauley, I represent the American Association of Anatomists. I think most of us who have been involved in these discussions applaud the efforts of Dr. Galusha and his group; certainly the Federation has come a long way in developing Flex One and Flex Two.

Over and above some rather deplorable examinations that have been given in the past for licensure.

However, I did not get a satisfactory answer to one basic question -- and that is, why not both routes, why can't we use both the traditional national board examination as well as Flex One and Flex Two towards licensure?

I asked the question a couple times -- I got several answers from Dr. Galusha, none of them were satisfactory to me. I don't like being involved in discussions where the decision has already been made, and I have a feeling that many of us share that opinion that I have right now.

The National Board says that it will control the content of the CQE. I wonder. Eventually, what's going to happen? Who pays the piper? If the Federation is ordering the CQE, and the CQE is the principal effort of the National Board, and it could ultimately evolve, or dissolve to that point, then who will control the questions that go into the CQE, who will decide how important basic science or any other specific discipline is?

Now, Dr. Holden has proposed that the certification by the National Board still be maintained by coupling it with Flex One and Flex Two. This is an interesting proposal. However, I don't think it has enough teeth in it to protect the interests of the basic sciences, or the National Board of Medical Examiners.

There are two possible ways of solving the dilemma, at least there are two or more possible ways; two that were discussed in our group were that the deans or the LCME insist that all students take part one of the National Board exam. I'm not sure that they're going to do that, but that is one possibility.

Now, academicians generally recognize the importance of the basic sciences, and I think that one way we might get around this problem is that if all academies insisted that the students going into their various programs would have to pass part one of the National Boards; that ultimately, before standing for their boards, they would have to become diplomats of the national board; that is another possibility.

The problem that I see is that only seven or 10% of the questions in the CQE are devoted to any one basic science, and that they're interwoven with the clinical discipline, and the clinical questions in such a fashion that you're not really testing the student's knowledge in these given basic sciences.

If part one is no longer required, it will have an impact on the basic sciences. I don't think there's any question about that, it's going to have a serious impact on it.

Moreover, I also submit to you that if part

one is no longer required, it is going to have a very serious effect on the clinical sciences, and on the quality of physician that we turn out.

It may be inappropriate at this time to make a motion.

DR. FREEDMAN: It's not a business meeting at this time. We'll have one later.

DR. PAULY: All right. Okay. Later, I'd like to make a specific motion.

DR. FREEDMAN: Right.

Anyone want to ... yes, Brian? Brian Curtis.

DR. CURTIS: Brian Curtis. A couple things. In terms of timing, let's try some dates on you. If we gave an exam November one, we should have results back by December 15th, which would be available then for students starting residency January one, and that presumably will be the time that most students would take it for the first time.

I think November one is probably late enough so that most fourth year students will have done all of their requirements before then, and then a second administration May one will give students plenty of remedial time for results back June 15th -- time enough to start July one residency.

Late enough return of results to discourage medical school faculties from abrigating their responsibility for

setting their own requirements for the MB degree. And I think there has been a drift, and it's always easier to blame the guy in Philadelphia or the guy in Chicago or the guy someplace else for your failures, than it is to stand up -- but I think as faculty, we have got to recognize as our personal responsibility.

As far as the boards controlling curriculum, my observation is that in most medical schools, they've done an excellent job of ignoring public health, preventive medicine, and to a various extent --behavioral sciences, even though the boards have very enlightenedly seen to put those in.

Lastly, I think it's fair to say that it's important that we move forward together, I think our hope from the academic side would be that there are some benefits to us in comparing our students with the national norm, not only in a single score, or possibly even a single pas/fail, but in some subdisciplines. And that I, for one, would urge that the board move forward in finding ways to report out sub scores.

I understand that there is some concern that the sub scores may be based on less than 100 questions, they may not be quite as valid as they are at the moment. But I think that there is information there, tremendously useful -- certainly to the people who fail, of knowing where their

strengths and weaknesses are.

So I would urge us to think hard about that, and urge us to work hard with Dr. Swann in getting some more good correlation between basic science, clinical science and good basic science questions in there that -- I think we can all say represent the best testing we can do in the 1980's.

Dr Freedman

DR. : Brian, your name is on this tape in a variety of ways, but since you have supporters, maybe they will be known as 'Swannees'.

Just a minute -- I wonder if the question that was raised about -- does this group understand what pressures the state, the Federation has been under? The question has been asked, what problems does a Federation have with using both current system and any other system?

And I have a feeling that most of the CAS members don't understand the problem of the Federation sees, even though you probably gave three answers -- is that it? Did you want to talk to that, Brian? Galusha.

Dr

DR. GALUSHA: I don't know anything, Dr. Pauley, that I should add today that I didn't yesterday. I guess, first and foremost, state boards are charged with the responsibility of doing certain things -- and I guess it's a legal mandate that state boards assure in a formal fashion the public, at least that that board thinks that they are prepared to do

certain things in a respectable and reasonable way.

[redacted] I thought I made it clear that we're not proposing Flex One and Flex Two just for foreign graduates. We're not excluding United States graduates. And although you in the academic community are responsible for medical education as a whole, and I am fully aware of the LCME, and the other checks and balances -- it's very difficult to get down to the individual unit of position. And that's what we're checking on; that's what we're charged to check on legally.

As far as some of the professions of preventive medicine and others, I can tell you, as recently as six months ago, there were radiologists in North Carolina delivering babies in rural hospitals, who never had any obstetrics.

What I'm saying -- we do not have licenses to practice preventive medicine; we don't have a license to practice psychiatry, we don't have a license just to practice thorastic cardiovascular surgery or neurology.

We have a license that gives a great deal of lattitude and some people can take advantage of that lattitude -- and with the plethora of physicians coming on in this country we're already beginning to see abuses of that privilege.

So, many of us feel, regardless of the specialty, that physicians, the profession of medicine, the physicians should have a certain broad base of knowledge.

While I'm here, I'd like to reiterate that there are many people on the Federation who are much stronger allies of basic medical scientists than any you can possibly realize -- and I thought that was one of the positive things, Dr. Johnson, that came out in our discussion group.

We have reason to be possibly more concerned than the basic medical scientists. I'm not giving this as any admonition, but I'd watch very carefully when you structure any motions that you realize you have some friends, and I don't care how close friends can be, sometimes they can be lost if they don't understand.

So, please be careful about this. I'm sorry I can't answer the question any better than that, because those are the reasons and those are the restrictions.

Dr Freedman
MR. : Dan?

Dr. Federman
MR. : I would like to make one point, and then return a question to the licensing board.

Although I think the Swann approach which we have been referring to, is a strong feature of it, I think there's an intellectual error in it. It is not the present relevance of basic science to the first year post graduate medical education that makes the basic science part of graduate educatio

And to assume that that will test it is misleading. I don't say this against Dr. Swann; he knows that much better

than I do, but we've been assuming that that restoration of basic science to the immediate clinical decision is the issue. I think that's just what's not the issue.

But, I wonder if we could clarify the thing further by asking the state licensing boards what component of CQE and the present process will prevent a radiologist from delivering babies or insure that he or she will do it safely -- because I would assume if that's part of the problem, the solution should be inherent in the proposed mechanism, and I would wonder, since I happen to agree with you -- I think the licensing function at the moment, a general license to practice medicine and surgery, which is what most of us get -- is archaic.

So that I think the problem you have, we share, but I don't see how this is the solution. And I wonder if we could ask that.

Dr. Galusha

MR. : Sorry. No comment?

MR. (CHAIRMAN)

Dr. Rattoff

MR. : Oscar Rattinoff. I have the great advantage of not having been here yesterday, and not having heard any of the preceeding discussion. I've tried to read what was presented to me in writing, and to listen to the various summarizers this morning.

The first thing this man from Mars finds when he comes here is no true expression about why one examination

is better than another -- it keeps you busier than another to keep changing exams, but first you've got to show me, by some more objective thing than I've ever heard in my life, that you're going to produce at the end a better physician, whether he be a practitioner, an academician, or an anatomist -- by one examination, as opposed to another. I just haven't heard it anyplace.

I would like to go on in this vein for a long time, but I'm not going to because I can get very, very boring -- but ...

MR. : (INAUDIBLE)

MR. RATTINOFF: Thank you, sir! But when I listen to statements that examine -- written examinations are going to make the radiologist deliver babies better, or perhaps written examinations will make, given to the mother, will make her able to read the certificate in the doctor's office, so she moves out of North Carolina perhaps to some state where there are real obstetricians, I don't know.

Note that the statement we just heard about this marvelous examination question for us all -- if there is a criticism of the system because the radiologist delivers a baby, maybe what we're hearing is that all that blabber which I've never believed anyway, about the virtues of family medicine, is just blabber, because really, what we're saying is you've got to examine each person in the skill in which he

intends to use in later life. And then, of course, you're going to tell me how you're going to do that.

Dr Freedman
MR. : Things are beginning to heat up -- just at the time I thought the discussion was dropping. But ... Edie Levitt?

Dr.
MS. LEVITT: Thank you, Mr. Chairman. Just a few comments. I might just pick up on the last speaker and point out that perhaps you and perhaps we are atrributing more to an examination than anyone ever really believes a single written, cognitive assessment process can do at a given point in time. I don't think that anyone here or at the National Board or in the licensing system would for a moment accept the results of an examination as the sole basis for determining whether or not an individual is a qualified physician, or a student capable of moving on to a subsequent year in training -- whichever it may be.

Obviously, the licensure system today and the national board certification system today have as a fundamental prerequisite the granting of the MB degree. So that with all of this, I think we're failing to recognize that what that degree notes in terms of the judgments of medical faculties is an integral part of any process that is ultimately going to result in the privilege of licensure to practice.

I would like to just comment briefly, also if I

may, to the comments in response to the earlier speaker, I believe, Dr. Pauley -- relative to the part one examination. And I think there is need to clarify perhaps a misperception there.

The only requirement that now exists for the part one examination is a requirement that's placed on students by medical school faculties, and this is true in some 75% of medical schools, quite irrespective of the National Board's certification process.

That is the sole requirement -- the national board system is voluntary, as you all know, and whether or not students choose to take part one, unrelated to a faculty requirement, is their option.

So that what is being proposed and discussed here is really no change from that voluntary process. And I think there is somehow the notion that the national board, as an organization, is in the position to impose requirements on students or in some -- to some extent, on medical school faculties. We are not. We offer examinations which we hope are of sufficient quality that those who do have the responsibility to make those requirements or to accept them, as is the case of the state medical boards, will do so. But the national board itself cannot impose these requirements.

I think it's just -- finally, the other comment is that whether we're speaking of the CQE or the current examina-

tion system, it's important to recognize that our credential is negotiable and useful only to the extent that individual licensing boards accept it. It's as simple as that.

Otherwise, our certificate has no value for licensure, unless it is accepted by the licensing boards. So that there is a responsibility there, and has always been, to make decisions as to whether or not they find our examination process acceptable for their purposes.

Thank you.

Dr Freedman

MR. : Thank you, Edie. Dr. Chase?

Dr.

DR. CHASE: Well, first of all, as usual, I'd like to agree with what Edie Levitt said, 100%. But in addition, I've heard a question raised now by three of the reporters from the discussion sessions, and from two other individuals in their discussions on the floor, on the generic question of why a CQE?

And I think we ought to address that for a moment, and perhaps it's not my place to do it, but perhaps more for the licensing organizations to do it; however, I'll assume that position for a moment.

Why a CQE? I think in our discussions of all of the implications of the CQE as a prospect, we've lost sight of the historical basis for the CQE in the first place. It was based largely and primarily on the interval, the so called unlicensed interval of physicians that exist today,

and that is, once a person acquires an MD degree, no matter where that MD degree is from, whether it's a U.S., Canadian school, foreign medical school or what -- he may enter the graduate education stream and assume responsibility for patient care which clearly has a different level of individual responsibility than he ever had as a medical student.

And I think that the licensing organizations are irresponsible unless there is some external evaluation to the extent that an examination can do it, of individuals entering that stream at that point in time. These individuals remain, quote, 'unlicensed' for what ever interval that state will allow that person in a period of graduate medical education.

The assumption, therefore, is that an MD is an MD is an MD -- and I don't think we can even agree that an MD is an MD is an MD, even if we confine ourselves to those from accredited schools in the United States and Canada.

And the discomfort has increased remarkably with the addition of a whole host of new MD's entering our stream in large quantity from the U.S. foreign medical graduate population, as well as the alien foreign medical graduate medical population, the DO's and others that are entering this licensing stream.

So, I simply wanted to point out that I think that was the primary purpose for the development of an evaluation, an external evaluation of MD's at this point, where they enter graduate medical education.

Now I do see some fallout benefits from that that I think are exceedingly important, and I'll name one -- and that is, it does finally result in one common pathway for all MD's, whether they be U.S. foreign medical graduates, foreign medical graduates -- alien foreign medical graduates, DO's, MD's from accredited schools in the United States and Canada.

And, for the first time, at least we can look at these individuals and put them on a scale related to one another, to the extent that, again, that with the limitations imposed on us by use of an examination as the only instrument. However, just because it is the only instrument, it does not evaluate all of the requisites that one would want to evaluate for a person entering the practice stream. At least it does evaluate that person's cognitive information, some of his problem solving skills and so on.

Therefore, I think we ought not lose sight of the purpose of the CQE in the first place by getting into a deep discussion of the other implications of that process.

Dr. Freedman
MR. : I must save my own reflection, and I wonder if, you know, the Federation and NBME people heard

this, too -- was that in losing an exam, or I guess we're losing an exam that once tested people in the clinical sciences, in academic medicine, which would be, what -- part two? Was a test in clinical sciences; I haven't heard any discussion of that as a scholarly issue at all.

I get the feeling that some new tools are being developed for some special puruposes that I think have been well articulated -- and a kind of an experimental exam. You know, and I also get the feeling that the Flex exam that the states do offer must create some problems. It isn't that there aren't exams in place, Bob, I don't think the issue has been exactly clarified, at least from my muddled head --

Dr Chase

MR. : Excuse me, but I keep hearing this raised again and again, that there is somehow the disappearance of examinations.

Dr Freedman

MR. : Yeah.

Dr Chase

MR. : And yet, I have not heard that these examinations will disappear simply because of the development of a CQE, unless there is no longer a use for those examinations and that's why I support with as much power as I possibly can, the retention of national board certification, although I do think it needs to be modernized if, in fact, a CQE is developed.

And I agree with Edie, that part one, for example,

is not required by licensing organizations at the present, but it is required if one wants to have a national board certificate.

Dr Freedman
MR. : Right.

Dr Chase
MR. : And I don't think one ought to play down the importance of that national board certification.

Dr Freedman Drucker
MR. : Dr. ~~Gerber~~ and then Joe.

Dr
MR. DRUCKER: Bill Drucker from Rochester. No way can I qualify as a 'professional' in preparing examinations; I guess I've taken a fair number -- but I do have some experience in medical education, and would support as strongly as I can the concept of a part one national board examination for several reasons.

It provides, at least the best we have available today, a quantitation of some sort of information and use of the information in solving problems, relating to basic science.

If I heard what Dr. Fetterman was saying, I would support that to a tee; that this concern about the relevance of basic science to clinical medicine is fine, but basic science has a right to be in a curriculum in its own right, and it doesn't have to be defended so completely and totally by its relevance to clinical practice.

We would do basic science a great harm if we tried to put it in the curriculum and keep it there and test

it, only on the basis of its relevance to clinical medicine. I speak as a surgeon, not as a basic scientist -- although my research is largely involved in physiology and biochemistry.

I think that the knowledge that a student has is exhibited on part one when the national board gives us considerable confidence when we are making the judgments as to the future of that clinician -- whether he will be in a particular specialty, whether he'll be granted a residency in our particular program, and some idea about the school he comes from -- having prepared them, with all due respect to Duke where my son graduated -- they have a lousy basic science course, only because they only spend a year on it. But they're magnificent students, and they get it later.

So I think we've got to be careful in how we evaluate the part one examinations, and I use Duke as an excellent example, Dr. Hill -- superb course, but it takes time for the students, they can't pass ..

Dr Freedman
MR. : Well, they work hard playing basketabll, you see.

Dr
MR. DRUCKER: They haven't beat Virginia yet -- I hope!

Another point about part one, and I have two other points to make -- is that it can be used to help us, I think, in our difficult problem with the foreign medical graduate. If the foreign medical graduate is required, before

he can take, as a prerequisite to taking, a licensure examination, some rigorous examination that indicates that he, too, has gained a body of knowledge that we expect of our students, I think we can help solve that problem.

Now, speaking of the foreign medical graduate, my second point is we've got to be terribly careful in whatever we put up in the way of barriers, that we don't completely exclude foreign medical graduates. We all know -- we only have to look at our own faculties to know the number of people on them who have come from foreign schools. They're tremendously valuable.

Look in our communities, and we find any number of excellent foreign medical graduates who are doing a superb job in practice. So I think we've got to be awfully careful that this isn't a totally shut door in our exclusion process, using the examination as a means of excluding them.

And now, my third point -- looking at, as I understand it, Flex Two. I'm terribly excited about Flex two of what it can do, I am concerned about what it might do -- and I see some very great optimistic things of what it can do. I'm very concerned that if Flex Two comes along, it will have a detrimental effect on our residency program if it makes the students, now residents, be concerned that they've got to pass this darn thing to get their ultimate licensure, that they cannot narrow down to the specialty that they have now chosen, no matter what that specialty is.

They're going to be burdened with in service training exams, they're not going to have an opportunity to go back and remain alive and cognizant of the things that they knew as a fourth year student, and certainly not as they knew as earlier students.

And yet, again, this very process can be the thing we need to pull the clinical disciplines together to plan residency education. Yet, there's one major failing that I can see in American medical education -- we stop planning together for clinical post graduate education. Flex Two could very well be a vehicle to force us in to that mode.

Dr Freedman (MR.): Joe?

Dr Johnson (MR.): I just have two quick comments, Danny. In responding to Edie and Dr. Taylor, I think that many of us would like very much to keep the diplomat route available certainly for diplomats, to whatever degree it's dislinked or unlinked from the licensing process.

And the concern we have is that at the moment, somewhere between 81 and 85% of students apparently use this route to licensing. If in fact, it is no longer a route to licensing, many of us are very much concerned that part one, although now taken by large numbers of students, would no longer be taken, nor would schools somehow feel the necessity or could defend the necessity of requiring part one for students.

So I think that's part of our concern, that we need to preserve somehow, and we would be concerned that we may in fact lose many students going the diplomat route.

The second point, and the only other comment I would make -- we are all in this together. The state boards have the legal responsibility, which we acknowledge and that we think is crucial, and we applaud, I think -- I believe we all applaud the significant progress they've made, and Dr. Galusha has expressed, I think, and has told us about some of that --which we applaud.

We also have legalresponsibility. We, in fact, the medical schools, for example, an MB degree is a requisite for getting licensed, and we grant the MB degree, so we are in the legal process.

Beyond that, many schools, including particularly state schools, have a legal responsibility to admit students and to process them and to grant the degrees. So we all face problems in both arenas, I think, and somehow we need to work together.

I hope this conference has succeeded in some progress in that direction.

Dr Freedman

MR. : Yes. Thank you, Joe.

Dr.

MR. MAYER: I'm Bill Mayer, and I'm here wearing multiple hats. You know, as Vice Chairman of the National Board and a member of its Executive Committee for 12

years, and as Chairman of the infamous GAP Committee that got some of us in to all of these discussions; I'm also here as a distinguished service member of this association, and here as an academician who has responsibility for an academic institution in medicine, and I suspect here also as a card carrying pathologist.

And I relate all of that because that's relevant in part to what I'm about to say, I think.

I have sensed over the last, now, eight years, nine years, that the ferment about these issues that has gone on -- I think real progress is being made, and is being made on several fronts within the academic community, it's being made by the Federation, I think it's being made by the national board.

There's one theme I've heard coming out of this meeting, which -- as a concern, and it's a concern which I personally share as one of the real remaining concerns in this whole issue. And that is the concern of maintaining the national board certification as some kind of equivalency for licensure.

You heard yesterday from Bill Holden the recommendations coming out of the Executive Committee of the national board at its meeting two weeks ago. I think those are positive, strong recommendations. You also are aware that it is the individual states that will decide whether that

certificate is picked up for licensure at the end of the line.

I think this association could provide a superb service by strongly coming down on the side of recommending that indeed, that national board certificate as proposed by the Executive Committee is indeed acceptable as a route to licensure.

And I would submit that those decisions are going to be made in your individual states, by your individual legislators in the years to come -- and therein lies the ultimate potential for assuring in fact, that that I hear many of you desire is in fact, maintained.

So I would suggest a strong recommendation by the AAMC to that effect, as being extremely helpful to future discussions two years, five years, ten years even, down the line.

Dr Freedman
(MR.) : Thank you. When we started discussing all of this yesterday, we pointed out that there has been a long relationship, and an intrinsic one, between the Federation and the board and these faculties. And I have a recommendation, as we bring this to a close, and that is that there will be the invitational conference of the national board in March -- is that right?

I think some time for reflection will be useful because there are a lot of problems to sort out. The exam itself for which we were asked to respond -- you had

62 representatives here from 51 of the 71 societies. I think some of this discussion probably will be going back to faculties, and I think some reflection, some chance for our own committee to pick up these reflections will probably be very useful, very constructive, as time goes on.

I have only one message before I conclude, and I want to then call on one person, and we'll have our coffee break -- and that simply is, I took advantage of the Gideons last night, because there seems to be some trouble brewing, which we'll be discussing in about 20 minutes, and there is a message from Cornithians which says we're all part of the same body. That's my benediction -- Bill Holden, what's yours?

DR. HOLDEN: Dr. Freedman, thank you for the opportunity to make a short final statement, and it is not a 'benediction' I can assure you.

I do, on behalf of the national board, wish to express our great appreciation to the AAMC and the Council of Academic Societies for giving us the opportunity to discuss this whole process of the national board examination system in reference to the licening process and the needs of medical education, as openly as frankly as it has been done in the last day and a half. It's been a great pleasure for us.

The five members of the Steering Committee for the CQE have all heard what you've had to say -- Dr. Kaeschner, Dr. Scherr, Dr. Swan and Dr. Barker and myself [illegible] -- and I can assure you we will take all of these many frequently erudite comments in hand, and consider them both as a committee and as representatives of the National Board of Medical Examiners.

Thank you very much, sir.

Dr Freedman
MR. : Thank you. We'll break for coffee and reconvene for business at 10:30.

(CUT)

(END OF PROCEEDINGS AS RECORDED)